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ORIGINAL ARTICLES.

THE PRODUCTION OF BRONCHIAL BREATHING IN CONSOLIDATION AND OTHER CONDITIONS OF THE LUNGS.[1]

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THE title of this paper is perhaps subject to misconception. It includes the discussion of the physical principles involved in the production of tubular breathing, and suggests that these same principles induce the broncho-vesicular and cavernous breathing, which differ from the first only in degree. There has been some little controversy upon this subject, limited, however, largely to those authors that have practical minds and a fancy for acoustics. Most of our modern text-books contain descriptions of the sound, and account for its production by quoting one of the few authorities that have written on the subject. The explanation offered by Laennec, and still held by some, was that the sound was produced by the vesicular murmur being cut off and the tubular or bronchial sound alone being audible. In the fourth edition of his work he expresses himself as follows: "The sound observed in the larynx, trachea, and larger bronchial trunks is due to the absence of that slight crepitation that accompanies the dilatation of the air-cells of the lungs, and the idea of a drier sound is suggested to us. It is strong in most parts of the neck. When the texture of the lungs becomes indurated or condensed from any cause, such as pleuritic effusion or the changes occasioned by a severe peripneumony or hymophysis, the vesicular respiration having then disappeared, or being much lessened, we can frequently perceive distinctly the bronchial respiration, not only in the large, but even in the small ramifications of the bronchi. The cause of this bronchial respiration appears to me very obvious; in fact, when the air is prevented from penetrating the cells this is the only kind of respiration that can exist, and is louder and more distinct in proportion as the lung is more condensed and thereby becomes a better conductor of sound."

Dance, a French authority of later date, adopts virtually the views of Laennec, and states in the *Dictionnaire de Médecine, ou Répertoire Générale des Sciences Médicales*, of 1833, that bronchial breathing is present when the air passes through the bronchial tubes without reaching the pulmonary cells. It produces in the ear a sensation of columns of air winding in the tubes of a certain caliber, without the sound of vesicular expansion; sometimes the sound is so intense as to make it seem that the patient's breath is passing through the stethoscope instead of through the bronchial passages.

Skoda thought that the tubular breathing was the transmitted laryngeal sound intensified or otherwise altered through what he called consonance; but he does not use this word in its ordinary acoustic sense, but explains that he applies it with the compound meaning of consonance and resonance, applying the principles of the sounding-board to obtain the intensity that he suggests. He does not make his views clear, except so far as the principle is concerned. The following is a translation of what is written in his *Abhandlung über Perkussion und Auskultation:* Bronchial breathing can be higher, stronger, deeper, or weaker, or even just as high and as strong as laryngeal breathing, and is due to consonance in sound in the upper and lower portions of the air-passages; the difference in volume and pitch depends on the condition of the inner lining of the air-passages in admitting of the production of the consonant sounds.

The most elaborate treatment of this subject that has come to my notice is found in Flint on the *Respiratory Organs*. Here Austin Flint devotes considerable space to this subject, and concludes by regarding bronchial respiration as "consisting of transmitted sounds that are produced within the trachea and primary bronchi, and probably also within the subdivisions of the latter, and are conducted by the air in the tubes and the consolidated lung to the ear of the auscultator. In what proportion they are due to the trachea and the larger bronchi exterior to the lungs, and to what extent sounds generated within the pulmonary bronchial subdivisions may be combined, are points not easily determined."

Flint certainly had an analytic mind, and his description is the most satisfactory. More modern writers adopt this view without notable modification. Guttman devotes fair consideration to the opinions of others, but expresses his views as follows: "The bronchial respiratory murmur heard in disease is nothing more than the laryngeal sound carried with scarcely diminished intensity through consolidated

[1] Read at the meeting of the Association of American Physicians in Washington, May 24, 25, 26, 1892.

lung-tissue." The views of R. C. M. Page and Vierordt are virtually the same. So also are those of S. S. Burt, excepting that the latter speaks of the sound as being transmitted through the bronchial tubes as through a speaking-tube, directly to the surface and ear of the auscultator. It will be observed that there is no great variety of opinion, and, without quoting at greater length, authorities are not fully satisfied with their own explanations, for they quite universally acknowledge differences of pitch over different regions in the same individual, and even contrast the laryngeal and tubular pitch, pointing out differences that all will concede could not exist if the source of the sound were the same, for pitch cannot be altered by the medium of transmission, and, as Dr. Flint says, "there are circumstances which give rise to variations in pitch which we do not understand, and that the sounds generated within the trachea and bronchi as in conditions of health, will not suffice to explain the intensification of sound which sometimes characterizes bronchial respiration in disease, nor the disparity in pitch which is observed." He further concludes that "other physical influences are doubtless involved which are not as yet satisfactorily explained."

Dr. J. Bloodgood, of Chicago, published an article on this subject in 1860 which has not received the consideration that it deserves, and my attention was only called to it within the past few days. In this article it is claimed that hepatization is not necessary for the production of tubular breathing and that the normal lung-tissue offers a good medium for conducting sound, as demonstrated by the clearness with which sibilant râles are heard when the parenchyma is normal; that when a bronchus becomes temporarily blocked by viscid mucus a clear tubular sound is at once detected, and this disappears when the secretion is coughed up; during the time it is heard the lungs are normal. Dr. Bloodgood argues from this that the air in its passage downward is diverted into many tubes the aggregate capacity of which is much greater than that of the trachea and bronchi; that it therefore rushes more and more slowly the more deeply it penetrates; that should a small bronchus become plugged at a little distance from its origin, or lead to cells filled with inflammatory product, it would furnish a cavity analogous to the Pandean pipe, and yield a tone determined by its size; that if it were located high up in the lungs, where the air has the greatest velocity, it would be intense, but if located in the lower lobes the sound would not be induced, or if present the intensity would be diminished. His argument is based upon false anatomic grounds, and he does not accord the transmitted laryngo-tracheal sound its place.

I began, about three years ago, a line of work and experimentation having the great charm called original work, which always acts as a wholesome spur, and after eighteen months of time it developed most successful results; but in that time I also made the discovery that my undertaking was not new, though I had succeeded without the knowledge that the ground had already been staked out by others. The work referred to is the making of casts of the air passages, and for that purpose I used an alloy composed of—tin, 4 parts, lead 8, bismuth 15, and cadmium 3. This alloy softens at 60° Centigrade, and fuses at 65°.

I do not know how my castings may compare with those made by others whose opportunities may have been better than mine, and who may have purused their work for a longer period than I did, for I have never seen any of the kind; my object is only to illustrate the basis of the explanation here advanced as to the causes that contribute to the production of the sound that we all term tubular or bronchial breathing. The castings are made from healthy lungs. These should be procured as soon after death as possible, and the cast is formed by pouring the alloy of low fusion into the trachea and allowing it to penetrate as far as possible into the tubes and vesicles before it chills and consolidates. It hardens almost immediately into a solder-like form, and the lung is then macerated in caustic soda, and eaten off, leaving the casting, representing what must be the exact caliber and shape of the air-passages, as far as the metal has penetrated, without burning or destroying the pulmonary tissue. I need not remind you that success does not attend each attempt, that the degree of heat, the pressure and the presence of moisture will modify the result and act as factors in the frequent failures, and determine the degree of success. In most instances castings of the larger bronchial tubes were obtained; in some, of the most minute tubular subdivisions; and, in a few, of the surrounding vesicles.

Whenever the vesicular castings were obtained the tubes were of course hidden from view. The castings were also not complete throughout the lung, and were often unavoidably broken off in the preparation, even by their own weight. Human lungs do not prove good specimens unless procured from subjects dying from hemorrhage and after a short illness, as the mucus always present debars the possibility of a perfect cast. The preparations were made from adult and infant human lungs, and the lungs of sheep, calves, dogs and rabbits. In many cases the alloy was poured into the trachea while the lungs were still *in situ*.

It is not within the province of this paper to discuss the anatomy of the lungs or to point out the errors that exist in some of our best descriptive Anatomies; but I particularly invite attention to the

method of division or branching of the bronchial tubes, which quite uniformly takes place at about the same angle, and uniformly by bifurcation, and that the air only reaches the air-cells after passing through a long route and varying in its course at the different points of bifurcation. Furthermore, at these points the bronchial tube possesses a sharp edge, which acts as a prow to cut the column of air at the bifurcation. This cutting edge is described in Sappey's *Descriptive Anatomy*, and he says that on a level with each division one sees in the cavity of the bronchial tubes a spur or prow to cut the column of inspired air. If the bronchi are given off at an acute angle this spur is very pronounced and very sharp. In collapsed lungs the bronchi are naturally much diminished in size, and this cutting edge is not very apparent, as it is not thrown out in relief; but in consolidated lungs, as in pneumonia, it is readily seen. I am confident that bronchial breathing is a mixed sound, composed of laryngo-tracheal and cavernous elements, the laryngo-tracheal sound being transmitted through the bronchial tubes by the air in their cavities, and thence communicated to the consolidated or compressed lung, to the chest-wall, and heard by the auscultator, diminished in intensity according to the lack of transmitting power of the different media through which it has to pass; that added to this sound in proportions differing under different circumstances, but often predominating in volume, is a *tubular blow* that is produced by the air rushing over the open and cavernous mouth of a patulous bronchus that leads to a lung not receiving its quantum of inrushing air.

Now, bearing in mind the cavities represented by these bronchial tubes, either of the first, second or third magnitude, the air-cutting edge referred to by Sappey, at the point of bifurcation, I believe we have the explanation needed for variations in pitch, as well as one of the contributing elements in inducing tubular breathing, and, perchance, the same tubular blow will be induced, whether the air is passing in or out of the lungs.

This point can be demonstrated by five figures of a purely conventional character, to illustrate how tubular breathing can be produced in the higher grades of pneumonia with consolidation; in pleurisy, with effusion, when the lung is in contact with the chest-wall; in necrosis, with a cavity; and how, when produced, it could not be heard in cases of effusion, if fluid intervened between the lung and the chest-wall. In all of these cases it is apparent that over areas in which tubular breathing is heard there is diminished or suppressed vesicular expansion. Under these circumstances it can hardly be questioned that, in order to reach other portions of the lungs, the air rushes by and over the bronchus leading to the diseased portion, to fill the air-vesicles that do expand, and that at the point of departure the cutting edge described by Sappey must produce a reverberation, engendering a sound analogous to that which would be produced by blowing over a test-tube; and its pitch will depend upon the length and caliber of this bronchus; this is the additional sound that, for lack of a better term, I have called the *bronchial blow*. If the rush of air to other parts of the lungs is rapid, the intensity of this sound will be augmented. If the size of the tube be small and shallow, its pitch will be raised; if large and deep, the pitch relatively lowered; but in any case, higher than a laryngo-tracheal sound, except in conditions of disease of the larynx, in which case its pitch might be raised much above the normal. When this sound is intense, as we find it in the rapid breathing of acute pneumonia, or extensive effusion, with the lung pressed or bound to the thoracic wall, it contributes largely to the sounds heard, thus raising the pitch and augmenting the intensity. Should rapid breathing subside in the cases named, or should secretion obstruct the mouth of the tube, or fill its cavity, then the intensity of this element would diminish, or the sound entirely disappear. The pitch of this blowing sound is determined, as has just been stated, by acoustic laws and depends upon the length of the bronchus and its caliber at its point of departure. The principle is susceptible of ready demonstration, with apparatus to be found in any of our offices. Blowing over a small test-tube will yield a sound of a certain pitch; on filling the tube partially with water, the pitch will be raised; a long, narrow tube will yield a low-pitched sound; a flask may be treated in the same way to illustrate the reverberation in a cavity. This experiment may serve to explain how, after a short lapse of time, both pitch and intensity of sound may be altered in conditions of consolidation by the presence of secretion in the tubes. I would further offer as an explanation of the exaggeration of the tubular element heard over cavities, particularly when they are near the surface, that the intensity is very much augmented by the proximity of the sound to the ear of the auscultator, and this rule applies equally to all physical sounds, and the more remote from the point of its production, the less audible it becomes; it is for this reason that sounds are sometimes limited to very small areas, particularly when the medium of transmission is poor. Again, sounds produced externally to the larynx cannot be heard with distinctness, and those which are most distinctly heard are produced at the periphery of the air-passages, or near the ear of the auscultator; labial sounds, such as chirping and whistling, are only heard as transmitted by the

external air; they are never intense, whereas any artificial means that produce a rush of air in the respiratory tract nearer the ear are markedly exaggerated, as, for instance, the expiratory "puffs," produced in this way; whisperings are intensified in like manner; the intensity of sound at different periods of respiration depends upon the same law. I do not think it would be possible to state what proportion of the sound is attributable to the different elements that go to make it up, for I am convinced that the proportion varies notably with different degrees of consolidation and under varying conditions, the discussion of which would be foreign to my purpose here. It seems to me that the reason why this explanation has not been offered before is because the size of the tubes has been very much underrated by those who are in the habit of making physical examinations; commonly when examined the lungs are collapsed and the bronchi are diminished in size, but the castings show that there are fully sixty tubes in the human lung capable of inducing a bronchial, blowing sound, while several bronchial casts in distended lungs have a diameter of about half an inch in the clear; these latter would certainly yield a large volume of sound.

Before closing I would not be understood as saying that the larynx does not play a rôle, and a very important one, in determining the pitch and quality of bronchial breathing, for I have experimented upon some of the lower animals, inducing pulmonary consolidation, and with an opening into the trachea I have been able to cut off the laryngeal sound at will; from this experiment, although it was not complete, for I found it difficult to produce pneumonia in a dog at will, I was convinced that the larynx, as well as the trachea and the *bronchial blow*, are the three elements that, in the aggregate, induce the sound that has been the subject of this paper.

SYPHILIS OF THE LINGUAL TONSIL.[1]

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ALTHOUGH the past decade has witnessed marvellous progress in every department of that branch of medical science that specially interests the members of this Section, in none, perhaps, has greater interest been felt than in the one that concerns the pathology and treatment of the various conditions that beset the adenoid tissue of the mouth and nasopharynx.

The introduction, by Waldeyer, of the term "tonsillar ring" into medical literature has led to a more accurate understanding of the relation of the various adenoid deposits to each other, both in structure and in function. Nor, moreover, is this term merely a fanciful one. There is almost a circular continuity of adenoid tissue from the nasopharyngeal vault to the tubal deposits, to those on the posterior surface of the soft palate, to the faucial tonsils, and to those at the base of the tongue.

Modern histologists have greatly differed as to what constitutes a typical tonsil. It seems to me that the recent paper of Harrison Allen(1) is at present the best exposition of the subject. According to this writer, a tonsil is essentially an association of diverticula developed from the epithelial layer of the mucous membrane. In the walls of these diverticula are grouped muciparous glands and lymph-follicles; and the mouths of the diverticula open in a uniform manner on the surface of the mass. The various tonsillar masses differ only in the arrangement of these anatomic units, so to speak. In the lingual or fourth tonsil they are single.

In spite of all we know regarding the structure of this tissue, however, we are still in the dark as to its physiology. Hingston Fox's theory (*Lancet*, 1888) of absorption has been discarded. Scanes Spicer's views as to their share in the blood formation (2), "nurseries for young leukocytes, planted by the waterside and drawing their sustenance from the streams nutrient," afford opportunity for pleasing phrases, but do not recognize certain obscure points in our knowledge. The fascinating doctrine of phagocytosis, advanced by Metschnikoff, caused many to think that the problem had been solved, but further investigations, carried on in a calmer frame of mind, have caused the profession to bring in the Scotch verdict of "not proven." Yet this doctrine is certainly worthy of consideration, for it fulfils, better perhaps than any other, the condition of a scientific theory, viz., it best explains observed phenomena. Hodenpyl, in a recent article, regards the functions of the tonsils as unknown.

The latest portion of the tonsillar ring to receive attention has been that localized thickening and broadening of the adenoid tissue at the base of the tongue. That we call the fourth or lingual tonsil. It is situated behind the circumvallate papillæ, and extends a varying distance toward the anterior surface of the epiglottis. It consists of closed follicles surrounded by irregular masses of adenoid tisse, the whole bound up in connective tissue. Our great advance in knowledge has come in the realization of this fact: that we have here, both in structure and in function, a tonsil, modified, it is true, by its situation, but subject to all of the mutations of tonsillar life. Stoerck, in 1877, first called attention to the trouble that its enlargement may produce by

[1] A paper read before the Laryngological Section of the New York Academy of Medicine, April 27, 1892.

irritation of the epiglottis. Since then many observers have reported various reflex neuroses arising therefrom. Curtiss has shown its effects upon the singing voice; Joal (3), how it may cause esophageal spasm and be a factor in globus hystericus; Heyman, Michael, Bentz, Rice, Swain, and others, have discussed the general question. Attention has also recently been called by Ruaulb (4) to the fact that we may have a peri-amygdalar cellulitis here, as in the fauces. He reports five cases of this affection: once in the median line, three times to the right, and once to the left. It is worthy of note that tonsillar hypertrophy here is generally confined to the middle period of life, while in faucial and retronasal situations the hypertrophy is characteristic of adolescence.

Furthermore, we have learned that the fourth tonsil is not merely a servile imitator of those pathologic processes that precede it in other segments of the tonsillar ring. It may present conditions entirely independent of those of its neighbors. These may be involved while it escapes. Natier (5) has noted that in syphilis of the faucial tonsils we may have a thickening of the ary-epiglottidean folds, with a tumefaction of the epiglottis by an abundant vascularization, while the fourth tonsil escapes intact. Schaede (6) has seen enlargement of the latter, while the other adenoid deposits have been in an atrophic condition.

The lingual tonsil, however, can lay claim to being the site at which diathetic influences may frequently localize themselves. Little attention has, until recently, been directed to its relation to the syphilitic virus. That such a relation exists is beyond dispute. We have heard much about chancre of the lip, of the anterior part of the tongue, and of the faucial tonsils with their pillars. From the sheltered position of the lingual tonsil, it can rarely, if ever, be the seat of primary infection. In fact, in a careful review of the literature, no such case has come to my notice. It is often the seat of secondary trouble, more rarely of the gummatous deposit, with its subsequent breaking down. This would be a logical deduction from the law of identity in structure and function, and one corroborated by clinical experience. Yet it is somewhat remarkable that the syphilographers, who go into such details in regard to specific lesions of other parts of the mouth, should have passed over the matter in silence, especially as now over thirty years have elapsed since the existence of true lingual chancre was demonstrated by Le Gendre. The causes of this condition and the circumstances that determine the localization of the lesion are, as far as we know, referable entirely to various forms of irritation. It is more common in men, and generally in young adult life. It is more common in those addicted to excesses in tobacco and alcohol; also, in those whose occupations require prolonged straining of the vocal organs. Further than this, the lesion offers no exception to the general rules of syphilis.

The condition is frequently overlooked because the symptoms do not differ from those observed when the pharyngeal walls bear the brunt of the trouble. When the localization is at the base of the tongue, in the median line, there is the sensation as of a foreign body. When it is confined, as it sometimes is, to the lateral portions, the function of the pharynx in deglutition causes more or less painful swallowing, the pain radiating toward the ears. The voice is frequently husky, and becomes quickly fatigued. Cough is frequently present, and not rarely asthmatic breathing. In other words, the syphilitic lesion occasions no other distinctive symptoms than may arise from simple hypertrophy.

It is in the pathologic appearances, perhaps, that the greatest interest centers. These may manifest themselves either in the median line or on either side thereof. Two different pictures present themselves—as best described by Moure and Raulin: (7)

1. Nipple-shaped protuberances, grayish-red in color, and separated by furrows. Their summits are ulcerated and crowned with the typical mucous plaque, clean-cut, and clearly differentiated from the surrounding surface. Each protuberance corresponds to a group of closed and inflamed follicles. The neighboring tissues are not at all involved.

2. There is at times a single tumefaction, median or lateral; a compact mass with slightly projecting swellings, the top of each of which is covered with mucous plaques, varying in size, diffuse and generally ulcerated. The whole mass is of ovoid or spherical shape, and the area involved is much greater than in the first variety. Here, while the closed follicles are infiltrated, the tissue between them is also infiltrated, and this interstitial infiltration is what goes to make up the mass. The epithelial layer of the mucous membrane and the submucous connective tissue both participate in the morbid process. There is not only a folliculitis, as in the first variety, but a peri-folliculitis as well—a folliculo-interstitial process. The transformation of the first type into the second is very rare. Of course, we must bear in mind that in any case the exact picture varies according to the normal distribution of the follicles and their size before infiltration, which in turn depends upon the preëxistence of simple hypertrophy.

The clinical history of a case that has recently come under observation, is as follows:

W. D., a colored man, thirty-one years old, was first seen in the Roosevelt Out-patient Department (in the service of Dr. Jonathan Wright), January 23, 1892. The man was a porter, stout, and of

rugged physique. His family history was good. He was a moderate drinker of malt liquors, and had used tobacco to excess. Last fall he had a slight attack of rheumatism, that did not compel him to give up work. In September, 1891, he had the initial lesion of syphilis. No alopecia or rash followed, but in December (about six weeks before coming under observation) he began to complain of sore-throat, with pain in swallowing. Examination revealed a normal nose. The faucial tonsils were swollen, and their surface more or less convoluted. The inside of the cheeks was sprinkled with mucous plaques, and the anterior surface of the tongue as well. A few superficial ulcerations existed in the naso-pharynx. At the base of the tongue, on either side of the median line, were situated lesions of the first variety, previously described.

Labit (6) has recently described a somewhat similar case. His patient was a male, twenty-nine years old, who had contracted syphilis six months before. No rash had been observed. Three months before the man was first seen he had begun to have painful spots in the mouth, with hoarseness and difficulty in swallowing. There was a general redness of the faucial tonsils and of the palatine vaults. The latter showed whitish patches, elliptical in shape, with uneven edges. There was an erythematous redness of the larynx, with slight inflammation of the ary-epiglottidean folds and vocal bands. In the region of the lingual tonsil the follicles appeared as projecting nipples, red, varying in size and separated by furrows of varying depth. The summits of some of these projections were covered with grayish ulcerations, contrasting strongly with the surrounding redness.

The tertiary lesions are more uncommon. Natier(5), writing in 1890, had been able to find the records of only fifteen cases in French literature. The diagnosis of this condition is difficult before the appearance of disintegration, and yet of the utmost importance, because the ulcerations may extend deeply and reach important bloodvessels.

A few words may be said concerning the differential diagnosis. This, as in doubtful specific cases, must be made from the history, the local appearance, and other evidences in neighboring parts. Schumacher (9) has called attention to one clinical manifestation that might give rise to some confusion. It is a local appearance met with, independently of mercurial stomatitis, in the pharynx of those patients who are being treated by inunctions. It begins among the circumvallate papillæ, and spreads backward to the epiglottis, attacking especially the edges of the pharyngeal and epiglottidean mucous membrane, passing down at times to the entrance of the larynx, seldom to the posterior laryngeal wall. At first there is only a slight dulness of color, but in a few days there are visible snow-white deposits, from one-half to one centimeter in circumference, surrounded by a zone of intense redness. If the condition be severe, the cervical and submaxillary glands may swell. Such manifestations generally precede the cutaneous eruption.

Concerning the early diagnosis of the gumma, we are aided by the induration of the surrounding area, the center of which will, if the evolution of the deposit be not checked, eventually support the deep cone-shaped ulcer characteristic of the fully-developed lesion. A suspicious sign is a slight thickening of the palate and the same side of the uvula. The absence of adenopathy is negative evidence. Its presence also does not greatly help us, because a unilateral glandular enlargement is characteristic of several affections. Moreover, carcinoma, chronic abscess, and diphtheria may all be attended with the radiating pains already alluded to. Here, as elsewhere, the grouping of features must decide the diagnosis.

Concerning the treatment of this condition, we are fortunately in a position to do much. The internal medication with the various mercurials generally yields prompt and satisfactory results. For local relief, we may at first need sedative applications. Natier has suggested a spray of potassic bromide with cocaine, in cherry-laurel water; Moure and Raulin, a gargle of Sydenham's laudanum in glycerin. For an alterative effect probably nothing exceeds in efficacy Mandl's solution of iodine, potassium iodide, and carbolic acid in glycerin. There is some danger in too irritant applications, as the epiglottis and larynx might be injured. Spasm of the glottis, and even edema, are not mere fanciful dangers. In the acute stage, the applications of dilute acid nitrate of mercury stimulate to healthy action. This, in my own case, with a sublimate gargle and mixed treatment, led to a cure in about five weeks. For inveterate cases, light applications of the cautery have served as a useful adjunct to other treatment.

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131 WEST SIXTY-FIRST STREET.

SOME PRACTICAL POINTS IN REGARD TO EYE-STRAIN.[1]

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MY reason—I will not say apology—for calling attention to this rather hackneyed subject is

[1] Read before the Georgia State Medical Association, April 21, 1892.

because in my daily work as an oculist I am constantly impressed with the observation that the vast majority of general practitioners overlook the easily substantiated fact that such a multitude of morbid reflex neuroses are brought about by eye-strain—that is to say, uncorrected errors of refraction. I refer especially to hyperopia and hyperopic astigmatism. As to myopia (near-sightedness), I have little to say of it, as it is rarely accompanied by headache and eye-strain. Myopes complain simply of not being able to see well enough at a distance.

Headache is by far the most common accompaniment of hyperopia and astigmatism. These headaches are most common in the temples, the frontal region, and vertex. They frequently appear to be what are known as sick or bilious headaches, and are in any case truly distressing in character. Among the other symptoms are a congested or inflamed conjunctiva, blepharitis, styes, chalazia, frequently an annoying and uncontrollable twitching of the eyelids, aching of the eyeballs, etc.

There is no doubt that chorea is often developed in children as a result of this same cause. There is, also, no doubt that in persons of neurotic temperament, indigestion, nervous dyspepsia, insomnia, and more or less complete physical prostration, are brought on simply from uncorrected eye-strain. There are plenty of these cases on record. I verily believe that there are very many helpless opium-habitués and inmates of insane-asylums whose unbearable suffering from this very cause was the cause of their first step in their downward career.

The incredulous general practitioner who has not yet become impressed with the truth in this matter will smile at what he not unnaturally believes are the vagaries of the hobby-riding oculist. Gentlemen, while I know that unfortunately there are riders of hobbies among oculists as there are in all specialties, let me remind you that the demonstration and correction of ametropia comes a little nearer being an exact science than any other branch of our profession. As for my own work in this line, I think it has been conscientious and painstaking. My books are open to you at any time; my patients are accessible to many of you throughout this section. They, and the results accomplished, can speak for themselves. I will try to illustrate by reciting two or three cases:

CASE I.—Mrs. A., a married lady, aged twenty-seven years, of neurotic temperament, has no organic disease, and for several years has been an almost constant sufferer from the most horrible headaches. Any attempt to read or sew would result in her having to go to bed with a sick-headache. Even when she went out shopping, a terrible headache was certain to follow. The poor woman had, fortunately, successfully fought against taking opium, but she afterward told me that she had almost concluded to ease her torture by resorting to morphine. She had unmistakably injured her system by taking great quantities of antipyrin, phenacetin, etc., and this was largely by physicians' directions. She became wasted and yellow, and was fast losing all hope of relief. Her very life was becoming rapidly blighted.

Now, strange to say, of the six reputable physicians who had treated her for her headaches, etc., five of them were men who would have promptly referred a case of granulated lids, iritis, or any other manifest eye-trouble to the oculist for special treatment, but only one of these six, and she a woman physician just out of college, seemed to suspect the real origin and cause of this patient's trouble, and she sent her to me, the patient protesting all the time that "she had no faith in an eye-doctor curing her headaches, because she had no eye-trouble—could see well enough," she thought, and her eyes were not at all inflamed. I found that her vision was, R. E. 20/LXX, and L. E. 20/XL, of the normal acuity. With a four-grain solution of atropine, dropped into her eyes night and morning, I found R. E. = 20/CC, L. E. = 20/LXX. From the very hour, by the way, in which I dilated her pupils, she got relief from her headache (so long as the accommodative paralysis lasted), and she informed me next morning that she had, for the first time in months, enjoyed a night's rest free of headache.

By way of digression, let me say, that it is a very good rule, when you encounter severe and intractable headaches in young persons (say persons under forty), to drop a few drops of a four-grain-to-the-ounce solution of atropine in their eyes, and very generally, not invariably however, if their headache is relieved, you can pretty safely put it down as a case of refractive error.

To return to my patient: I found the following remarkable condition of mixed astigmatism:

R. E. + 1.50 D, cyl. axis 90° ⊖ — 1 D, cyl. ax. 180°.
L. E. + 1 D, cyl. axis 90° ⊖ — .50, cyl. ax. 50.°

This may truly be called a diabolical error of refraction.

I prescribed these glasses, and knowing that she would soon become disgusted with the attempts to use them with undilated pupils, I began with dilated pupils, and predicted confidently that they would give her great relief, though I candidly told her that it might require considerable time to get her over her headache habit—for there undoubtedly is a headache habit, so to speak, a condition of periodic or constant headache that does become habitual. For several weeks thereafter, when she would become discouraged on the attempt to use her glasses, I would dilate her pupils. It required all my tact to keep her using them, but now, after many months have elapsed, I can truthfully say that the correction of this lady's refractive error has made life a very different sort of existence to her, and has changed her suffering condition to one of happiness and joy. She is free from her terrible

headaches, and has gained flesh and strength. Nothing else was done for her but the correction of her eye-trouble. She finds most comfort in the constant use of her glasses, and her vision with them now is, R. and L., 20/XX.

While such a peculiar astigmatism as hers is very rare, I could recite the cases of many patients, even with very slight degrees of astigmatism and hyperopia, who suffer with the most terrible headaches in consequence, and very many of these patients have normal vision. I myself have more than normal acuteness of vision, it frequently being as good as 20/XII, and yet I have an astigmatism of + .75 D, ax. 90°, and a hyperopia of + .75 D. If it were reduced to a question of simple comfort, I would prefer to give up my shoes or hat rather than my glasses. I said that we do not usually find eye-strain in persons over forty-five, for the reason that nature has brought on a change or loss of function in the ciliary muscle, so that they can no longer overexert it; yet, sometimes we do find that in such patients there is eye-strain or asthenopia.

CASE II.—Mrs. ——, aged fifty, of Boston, had been fitted with the glasses ordinarily proper for the presbyopia usual to one of her age, yet she has for many years had great trouble upon any attempt to read or sew. She suffered severely with eye-ache, styes, inflamed lids, etc. While spending the winter in this State she was advised to consult me. As I could find no other ocular trouble, I made a careful ocular test of her refraction. At her age, of course, I did not use a mydriatic. Her vision was 20/XX. I found that her Boston oculist, who was a man of reputation, had overlooked or failed to correct an error of one-quarter of a diopter of hyperopic astigmatism, which my test plainly showed. I prescribed glasses: + 2 D ⊃ .25 cyl. ax. 90°, for close use, and soon had the happiest results follow their use. She rapidly recovered from her eyeaches and inflamed lids, and now uses her eyes as much as she chooses. Bear in mind that this lady had the slightest degree of astigmatism that we ever encounter. I have no doubt that in prescribing glasses for presbyopia all occasionally commit the same inadvertence which this lady's former oculist did.

CASE III.—A boy, seven years old, had been growing more cross-eyed for nearly a year, but as it was of the alternating variety and not firmly established in either eye, his parents consulted me about a nervous twitching of his limbs, neck, etc. (chorea), rather than for eye-trouble. His vision was below normal, but this had not been previously noticed.

When I proposed to undertake the correction of his trouble by the use of glasses, they objected very vigorously to his using them, unless I could make the ridiculous, but very frequently desired, promise that their son would soon be able to leave off the use of glasses. They were willing, though, that I should perform an operation for the strabismus which, by the way, was now about two and a half lines. Of course, I refused to touch the case at all under these circumstances. I think they brought the boy to me half a dozen times during the year, asking me to operate on him. Finally, seeing that I was bound to have my way in the matter, they consented to an examination of the boy's refraction. His vision was:

R. = 20/XL. L. = 20/L.
Under atropine: R. = 10/CC. L. = 10/CC.
With + 6 D: R. and L. 20/XX, or normal.

I prescribed this full correction, and by keeping his pupils under atropine for two or three weeks he experienced no trouble in wearing his glasses. His strabismus and chorea disappeared at once, and have not returned after two years. The boy has been at school ever since.

I never cut a muscle when I can do what is necessary without it. This I consider conservative ophthalmology. Of course, when the squint has become firmly established, we have (usually) to operate as well as correct the refractive error.

My observation is that even in children when the error is as much or more than + 3 D, it is best to try to make them wear a fully correcting glass constantly. When the error in young persons is less than 2 D, I wish to state that I do not now so frequently prescribe a fully correcting glass for close use as I formerly did.

I shall not weary you with detailing accounts of cases showing the very long train of morbid nervous conditions brought about by uncorrected refractive errors. All these have been clearly proved to exist by faithful and painstaking workers in ophthalmology. As for myself, I assure you that I do not prescribe glasses for every case of small refractive error that I find. Many of these require general systemic treatment and toning up, and I send them back to their family physicians. Many others simply need a rest, or to stop abusing their eyes; and as I well know if given glasses they would simply continue to overtax their eyes, I generally refuse to prescribe glasses. I have good reason to suspect that there has of late been too much hobby-riding by some in the way of useless muscle-cutting for heterophoria. My observation of several years convinces me that eye-strain is not so much caused by a lack of equilibrium of the external muscles of the eyeball (heterophoria). Neither do my patients require prisms so frequently as employed by others. I am thoroughly convinced that the very great majority of cases, of eye-strain that I see are caused by ciliary strain, which is of course due, in the cases I speak of, to ametropia. I have very frequently found persons wearing prisms who were unrelieved thereby, and upon my searching very carefully I could find no occasion whatever for them, and have relieved many of them by leaving off the prisms and

correcting their refractive error. I am always willing and ready to compare results with the muscle-cutting and prism enthusiasts.

A word about mydriatics in refractive work. I believe I have thoroughly tested the comparative merits of atropine and homatropine, and while admitting the discomfort and inconvenience caused the patient by atropine, I must still say that homatropine is so very frequently unreliable, that in cases in which it fails to give accommodative paralysis I very often have to resort to atropine. In young persons under thirty I always, if possible, use atropine. Of all methods of exhibiting homatropine that I have used I consider the gelatin discs advised by Dr. Casey A. Wood, of Chicago, by far the best. As to the practice of attempting to correct these refractive errors simply with the ophthalmoscope, *i. e.*, without a mydriatic, I had as lief argue with a man who preaches against the value of vaccination as with a man that asserts that refraction work can thus be properly done.

The correction of refractive errors, gentlemen, is the most prominent, and by far the most scientific, part of an oculist's work, and I assure you that too many general practitioners overlook many of these cases. One meets with a hundred of these sufferers to one of cataract.

INTESTINAL LESIONS IN ABDOMINAL AND PELVIC SURGERY.[1]

BY JOSEPH PRICE, M.D.,
OF PHILADELPHIA.

IT is not my purpose to consider in detail all of the complexities and manifold relations of abdominal and pelvic surgery. I only desire to indicate the part that intestinal lesions play in making the pathology of abdominal and pelvic disorders complex, and afterward to consider the best way of dealing with the intestinal complications for the good of the patient and the comfort of the surgeon.

In order to appreciate the part that intestinal lesions play in obscuring the diagnosis and interfering with the surgical treatment, it is necessary to study the history of all pelvic pathologic growths, as well as of suppurative and inflammatory products found in the pelvis. Complications involving the hollow viscera during the progress of the growth or formation of these tumors and products furnish the chief danger experienced in the surgical relief of patients so suffering. It is rare that any suppurative process is ended without some intestinal complication in either the pelvis or abdomen. In the presence of such processes, universal adhesions to all surrounding organs is the rule. This is true of purulent deposits in the tubes, abscess of the ovary, and in the dermoid cyst, whether large or small.

The appendix, in my experience, plays no small part in complicating ovarian and tubal trouble on the right side; when this is the case this organ must be removed, though primarily it may not have entered into the consideration of the surgeon at all. In more than one instance, operations in which the appendix has been removed have been instituted for some condition not associated with the appendix.

It is plain that in order to be successful in the treatment of pelvic and abdominal troubles a comparative knowledge of the complications must be had. Aside from conditions brought about by purely pathologic processes, post-operative complications, due for the most part to hasty, ill-advised work, or unfinished operations, are at the bottom of a good deal of surgical complication that would not otherwise exist. Such operations are the worst that surgery has to deal with, because they involve both new and old inflammations, together with the effacement of anatomic landmarks that would otherwise exist. Nevertheless, there is much to be learned from these operations, just as we have learned much from the pioneer attempts of the earlier gynecologists, and a dexterity acquired in manipulating the complicated cases is of infinite value in the simpler ones.

In the same category may be placed complications due to failure to drain, and the use of irritating solutions. If we do not drain products likely to go on to organization, or if we use fluids that encourage inflammatory peritoneal adhesions, it is evident that we are at once on both horns of a dilemma, and the patient will be prodded from two quarters. Meddlesome interference with what would otherwise be natural drainage, by the introduction of quantities of gauze into the pelvis, must of necessity produce adhesions. The less the peritoneum is finally meddled with after the completion of an operation, so much more surely will there be an absence of damaging adhesions. What is required here, as in all work from which good results are to be expected, is to rely on logical procedures scientifically applied. Hop-skip-and-jump methods, while they are exciting and acrobatic, cannot be trusted to save patients.

Going back to a former assertion that the history of these growths is important in preventing the accidents of operation, in no other condition is this truer than in ectopic pregnancy. Here, if we hold in mind the almost inevitable complication of a bleeding tube, we are able at once to control the bleeding, and without loss of time in searching for the point of leakage, go at once to it and so save the life of the patient. In all bowel-troubles, in any or all of these conditions, rapid and accurate repair is of the most importance. That is not surgery at all

[1] Read in the Section on Surgery and Anatomy, American Medical Association, June, 1892.

that takes chances and leaves to Nature, so-called, what is only the surrender of ignorance or inefficiency. Inflammatory adhesions do not confine themselves to the intestines, but extend to all organs, hollow and solid. Such being the case, it is evident that whatever anatomic peculiarity each organ possesses is a necessary part of our surgical equipment if we hope to deal successfully with its lesions. In dealing, therefore, with the adhesions of the various organs, our anatomic, physiologic, and pathologic knowledge is put to the test, both as to what may be sacrificed and what must be saved, and toward which line the path of safety reaches. In this connection it is at once apparent that the mere theorist, or theoretic operator, or lecturer, may have little conception or idea of the operative requirements of a given case, and is, therefore, in no position either to advise or to perform an operation. The requirements of success are both scientific and artistic, both theoretic and practical. In no point is this axiom so apparent as in the method of dealing with adhesions, which so often fuse all adjoining structures into what seems a conglomerate mass.

Mere theory, and the theorist in abdominal and pelvic surgery, would say, Separate the parts and organs with the knife; while experience and experienced operators say, Use only the finger-tip, seeking a line of cleavage, and thereby avoid the danger of wounding tissues that must be separated. The methods of general surgery here are not applicable to intestinal work. Such means can only be safely applied to post-mortem work. No violent methods are to be employed; gentle, persistent effort is alone the safe and successful means. Cultivated, delicate tactile sense, attained only by having a sharp wit at one's finger-ends, is the key to the situation. The refinement of feeling possible is only possible of conception after it has been attained.

The complication induced by removing adhesions is hemorrhage. This we must control, not by ligatures, unless exceptionally, but by packing, if necessary, and by flushings of the bleeding cavities with water as hot as can be employed without interference with or destruction of the vitality of the tissues. This expedient will frequently save patients otherwise doomed. More than one case so saved could be detailed. In advising this procedure I know that I am running counter to the views of the theorists, who see in it all manner of dangers, but practice does not sustain them, and the surgical advantage obtained by the hot-water flush is indisputable. This is especially true in patients exhausted from any cause whatever. Irrigation is then a real requirement after any operation incident to purulent or other inflammation in the pelvis or abdomen.

In all suppurative and inflammatory abdominal and pelvic disease, the line of treatment briefly should be as follows:

First remove the diseased organs; then carefully flush the parts free of débris; and lastly drain carefully, thereby assisting the economy to rid itself of accidentally retained shreds and clots. After the adhesions have all been overcome, careful examination of the hollow viscera is to be made, or, indeed it were a better practice, to examine all doubtful portions of intestine, and repair them as we proceed. They should be mended so as not to interfere with the integrity of the bowel in the performance of its functions. This is the rule in dealing with all other organs.

In contradistinction with the entire and careful removal of the diseased parts, we have so-called conservative methods brought into bold relief—to their disadvantage. We are counselled to puncture and drain pus sacs *per vaginam*, in order to avoid infecting the peritoneum. This is another conflict between mere theory and practice. If pus-cavities, as we find them in the pelvis, were simple, and involved but a single organ—in fact, if they were something they are not—such treatment would be commendable; but if, as in the great majority of cases, the sac is only one of a number of complications, no one of which can be punctured away, we must concede that such expedients are not conservative, but only specious devices to escape depths in surgery through which their suggestors can neither swim nor wade, and hence they flounder in their despair, seizing this and that to lead them out of their perplexity.

A single illustration or two will suffice to show the deceptive nature of such tentative operations in so-called pelvic abscess. We know by wide experience that all abscess-formation in the pelvis is in the great majority of cases dependent upon tubal or ovarian inflammation, which is rarely uncomplicated, and in the majority of cases has involved intestine, often omentum; the bowel is often perforated; the bladder is not seldom implicated. We have seen too that the appendix is not seldom bound down in the almost universal adhesions. If now there is a lesion of the bladder through which pus is just ready to escape, or is escaping, simple puncture cannot undo the mischief, and the same is true if the appendix is involved, with tube and bowel. Granting that one pocket of pus can be emptied by puncture, this will not do away with the adhesions that are often the chief seat of pain, and are a constant menace to the patient by exposing her to the dangers of obstruction. The sequelæ of many of these cases treated by puncture and drainage is often a most mournful travesty upon surgery, as witness the histories given by the operators themselves.

In a discussion before the New York Obstetrical Society, and published in *The American Journal of Obstetrics* for March, 1892, Dr. Paul F. Mundé is quoted as saying that "during the last *few years* he had opened *forty* pelvic *abscesses through the abdomen, eighteen* through the *vagina*, and four through the abdominal wall and vagina at the same time. In several cases he had punctured the vaginal wall in order to secure thorough drainage, abdominal drainage not being sufficient. In three of these cases, while drawing the drainage-tube through from the vagina to the abdominal wound, the bladder was accidentally wounded."

Consider a total of sixty-two cases of accumulation of pus in the tubes and ovaries, due to occlusion and suppuration; that dilatation of the tubes in a majority of this group "attained the size of a breakfast sausage, a banana, or a closed fist." In this group the practical surgeon can understand that vast number of serious complications following, first, the delay, and, secondly, the palliative methods of so-called treatment. Early primary sections, with complete removal of pus-sacs, would result in a mortality of *nil*. A large number of the group referred to have gone into the hands of other men for treatment. Such cases are constantly coming to me; and, well knowing how much more complicated they are, I dread them. In somewhat the same line, Dr. Mundé says: "We have boils and abscesses in the cellular tissue of other parts of the body. Why should we not have them in the pelvis?" And again, in a recent publication: "The empty *sac*, *lined by pyogenic membrane*, may, for an unlimited time, go on pouring out pus." The comment I would make very brief: Boils and true abscesses are not empty sacs.

Again: "We will all admit that many cases of 'pelvic abscess' in former days were really adherent pyosalpinx. I have, doubtless, punctured many a one in past days, never dreaming that it was anything but an abscess in the pelvic cellular tissue. I know better now." The comment can here be made: No longer is it a boil or an abscess in the cellular tissue.

"One of the great problems in my experience," says Dr. Mundé, "has been the sinus that is liable to remain after opening the abscess. I am sorry to say that I know of no sure way to prevent or cure them as yet. I have enlarged the wound over and over again, scraped them, cauterized them, punctured through into the vagina, and run drainage-tubes through, hoping the opening would close from above downward, but all of no use. I have, I suppose, a dozen women walking about this city now who are wearing different sorts of drainage-tubes. I would like to have some gentleman tell me how I can prevent these sinuses in the first place, and, in the second place, how I can heal them up." In the interest of the patient, the best thing to do in such cases—in fact, in all cases in which we don't know how—is not to attempt to do the operation, but send the patient to someone who, first, understands the pathology; and, second, the surgery. To cure these sinuses, remove the remaining diseased tube and ovary. This will do away with the necessity of "walking around wearing drainage-tubes"—a very uncomfortable interference with locomotion.

A BRIEF SUMMARY OF THE CLINICAL HISTORY AND TREATMENT OF TWO THOUSAND AND TWELVE CASES OF ALCOHOLISM, OF WHICH EIGHTY-SEVEN WERE MANIACAL.[1]

BY THOS. S. LATIMER, M.D.,
OF BALTIMORE.

IN the spring of 1891, at a meeting of the Johns Hopkins Hospital Medical Society, I reported 958 cases of alcoholism occurring at the Baltimore City Jail, between April 11 and December 30, 1890, of which 40 cases were of *mania à potu*, with an average duration of mania of forty-eight hours.

In these cases no distinction was made between *mania à potu* and delirium tremens. They were simply cases of mania due to alcoholic excess, accompanied in most instances by hallucinations of abhorrent nature, with tremors, great feebleness, loss of appetite, vomiting in many cases, and inability to sleep. In the non-maniacal cases, all of the symptoms related were uniformly present (including tremor) except the mental disturbance. All were treated with potassium bromide; the maniacal cases with thirty-grain doses every two hours, and the non-manical with the same dose at intervals of four hours. No addition was made to this treatment, except in three or four cases in which ten drops of tincture of digitalis and five grains of ammonium carbonate at intervals of three hours were also given; all recovered.

Since reporting these I have had opportunity to observe in the same institution 1054 additional cases, of which 47 were maniacal. This report, therefore, may be said to be a brief history of the gross clinical features and treatment of 2012 cases of alcoholism, of which 87 were maniacal. No attempt is here made to discuss the pathology of alcoholism, or any of the symptoms, except those directly connected with the debauch in the habitual drinker. No reference is therefore made to symptoms presumably due to persistent hepatic, renal, or peripheral nerve-lesions.

Nearly all of these patients were arrested for

[1] Read at the Seventh Annual Meeting of the Association of American Physicians, held at Washington, May 24, 25, 26, 1892.

drunkenness and disorderly conduct. They were technically called "peace cases," to imply that they were arrested for breaking the peace. A majority of them were also what in the jail are called "regulars," from the regularity with which they were returned after very brief absence. Two noteworthy facts are contained in the foregoing statement:

1. The cases were all drunk when arrested, and many of them had not yet become sober when brought to jail.

2. They were cases of almost continuous drunkenness, culminating at short intervals in a severe debauch, leading to some act of violence, or to a condition of drunken stupor, in which they were picked up on the streets quite helpless and almost or quite unconscious.

It was also quite common for my hospital steward to say, "Doctor, this man, or woman, is a chloral-fiend," or an "opium-fiend," or a "cocaine-fiend." Indeed, the cases were quite indifferent as to the particular intoxicant, using one or the other as chance might determine. All used some form of alcohol when obtainable, but many were habituated to the use of other intoxicants of the class mentioned. This fact primarily determined the choice of the remedy uniformly directed.

It will be observed that here was a particularly unfortunate class of cases to treat. All, even though young in years, were old sots; many had had numerous attacks of *mania à potu;* many were addicted to the use of intoxicant drugs; many were the subjects of chronic alcoholic lesions, and of other loathsome and enfeebling diseases indirectly connected with their mode of life. They were, as a class badly fed, badly clothed, and badly housed, when not in jail or in the almshouse, and certainly no luxuries were furnished them at either of these places. Almost without exception, even with those that were not at any time delirious, they were without desire for food, often nauseated, sleepless, full of pain, muscular and articular, tremulous in tongue, hands and legs, and full of nameless terror.

In no single instance that I remember was the appetite for stimulants lost. Almost invariably the victims begged piteously for drink, which in no case was given them.

The jail-fare consisted of weak coffee, with coarse brown-bread for breakfast; some kind of soup, not very rich, with plenty of brown-bread and a chunk of poor meat that had been boiled with the soup, for dinner; no supper.

The cases slept in locked cells on sacks of straw on iron bedsteads without blankets, even in the quite cool weather of spring or fall. No pneumonic or pleuritic complications ensued from this exposure.

The second series of 1054 cases, of which 47 were maniacal, presented substantially the same history, were treated in the same manner, and with the same result. Besides these, two fatal cases occurred. In one instance, the patient was brought in after my daily rounds, in a condition of alcoholic coma, and died before I saw him. He was supposed by the officers of the jail to be in that heavy drunken sleep so common with these subjects, and was left to sleep off the effect of his potations without having been given anything whatever. He was found dead in his cell in the morning, apparently without having recovered consciousness. Whether this was a purely alcoholic effect, or if he had taken also, or alone, an overdose of chloral or morphine, or whether it was uremic coma, cannot be said, as I did not see him during life, and no post-mortem examination was permitted.

The second fatal case also came in in the evening after my rounds. He was said to be quite drunk, but was able to walk to his cell, which was on the sixth tier. He became somewhat delirious in the night, but not sufficiently so to make the night-officer think it worth while to transfer him to a cell on the ground floor, where all cases with mania are kept. In the morning, when his cell was opened, he sprang over the railing and fell to the stone pavement, receiving such injuries as to cause his death within half an hour.

Neither of these deaths can therefore be fairly charged to the plan of treatment, nor are they included in the 87 cases of *mania à potu,* since, as I had not seen the one before death, or the second before the fatal injury, I am unable properly to classify them. In the second series of cases 4 were characterized by great mental excitement, noise, and violence, without terrifying delusions. They, like all of the rest, had been drinking up to the time of arrest, and were given no alcohol after arrest. Of the second series 13 (of 47) were admitted with delirium tremens, and in the remainder (34) delirium developed after admission—in one case as late as seventy-two hours after. In no case did the delirium last more than five days. The average period at which these patients were enabled to do some kind of light work was about two days after treatment was begun; they were not then in such condition as to be declared convalescent, or, if they had been in private practice, to be allowed to leave the house; but here, where they were under constant observation, and where no opportunity to obtain drink existed, they were allowed to do such work as they desired, and all drugs were then generally stopped. Usually on the second night, but often not until the third, they slept fairly well; and by this time they also began to eat with apparent relish the coarse prison-fare. Food was offered them at each meal, but no attempt was made to urge it upon them if inclination did not prompt them to eat. In a very

few instances, milk, eggs, light bread and tea were substituted for the regular prison-fare, but these were seldom taken, and were usually withdrawn when appetite returned and a good sleep had been had.

No distilled or fermented drink was given in any one of these cases—no drug but potassium bromide, except in a few instances, in which great cardiac weakness prompted the use of tincture of digitalis (ten drops) and ammonium carbonate (five grains), or occasionally in very noisy subjects, in which morphine (one-fourth grain), and atropine (one one-hundredth grain), were administered hypodermatically, at night. Thus, it is seen that in 2012 cases of chronic alcoholism with acute explosions, 87 of which were maniacal, under circumstances of the most depressing character, all did well without the use of alcoholic stimulants. My conviction is strong that it was to the withholding of the alcohol, rather than to the administration of the drug, that the good results obtained were primarily due. No restraint, further than keeping the patients in a locked cell while delirious, was exercised. The patients walked their cells incessantly, and often destroyed the bedding in pursuit of imaginary enemies; but as it was of but little value they were allowed to do so, rather than bind them in bed, or even secure the hands. As the patients were usually alone at night, in a dark cell, I found that when they were bound it added greatly to their terror, and intensified the maniacal symptoms. I am moreover convinced that the unceasing walk, with its resulting weariness, tended to the induction of sleep at an earlier period than would otherwise have been the case. In no instance, beyond a few slight bruises, did any harm result from the absence of bonds. I have not observed that alcoholics are ever disposed to injure themselves. When injury is sustained it is in flight from imaginary evils, or in struggling to obtain drink. All attempts to secure the patient in bed, to bind or muffle the hands, are unnecessary. If he is securely locked in a cell, or by himself in a room, made bare of all superfluous articles, he is unlikely to harm himself. Friends or attendants within call or sight reassure him when his hallucinations are terrifying, but he needs no restraint from them, and may be allowed to wander about his apartment without let or hindrance, with advantage to himself, provided the windows are secure.

I have treated a number of cases of delirium tremens in private practice and in hospitals during the period covered by this record, but not with such results. Fatal cases are not uncommon in hospital, and almost as frequent in private practice. This I believe is mainly attributable to the fact that neither at home nor in a general hospital is it possible to withhold stimulants or such drugs as morphine and chloral, from consideration of other inmates of the home or ward. It must be remembered, however, that cases are usually carried to hospital for some disease-complication, whilst the merely drunken and disorderly are taken to police-stations and thence to jail.

Before closing this short report it may be well to add that nearly all of the cases considered were committed to jail for thirty days; this brief period of enforced abstinence exerted no appreciable influence on the disposition to the intemperate use of strong drink, since the cases almost invariably returned in from one to three months, and often within as many days, after release.

The study of the foregoing cases leads me to the following conclusions:

1. That the clinical phenomena attending excesses in the use of alcohol are the direct result of over-stimulation, and are not due to the abrupt withdrawal of the stimulus.

2. That though ability to swallow and retain stimulants is frequently wanting, the desire for them almost uniformly persists.

3. That alcohol in any form or quantity is unnecessary in the treatment of such cases, and is usually hurtful.

4. That the absolute and immediate withdrawal of alcohol is of the first importance in the treatment of all of the symptoms due to its excessive use, even in cases characterized by great feebleness and inability to partake of food.

5. That forced feeding is rarely necessary, and is of doubtful utility in most cases.

6. That for the protection of the patient no kind of bonds is called for, and, when necessary, for the protection of others, or for the contents of the room, they injuriously affect the mental state of the patient.

CLINICAL LECTURE.

EXTENSIVE RAILROAD INJURY; AMPUTATION —FISTULA IN ANO—PERITONITIS.

A Lecture delivered at Harlem Hospital, New York, April 20, 1892.

BY THOMAS H. MANLEY, M.D.

THE first case that will demand attention is one of extensive railroad injury of the left leg, which involves a compound dislocation of and fracture into the ankle-joint, besides a horizontal fracture through the astragalus. In fact, from the description that the house-surgeon sent me, immediately after the case was admitted to the hospital, it was conclusive that the limb must be sacrificed.

The history of the case is not without some interest and practical value; hence I will give it rather fully, as well as make a few observations on amputations necessitated by railway injuries. It is now thirty-six hours

since the injury was sustained. The patient is apparently a healthy man, twenty-three years old, with no organic disease. He says that while mounting a train in motion he was pushed off by the guard, and that the limb was crushed when he fell. The ambulance-surgeon arrived at the railway station about half an hour after the accident. He reports that he found the man bleeding very freely and in profound shock. Temporary dressings were applied; the hemorrhage was controlled, and stimulants were given. When the patient entered the hospital, though quite blanched, with a feeble pulse, he was somewhat hilarious. Great importance attaches to this feature of intoxication of the injured in railway or other accidents. But we must always be guarded in giving an opinion on this point, for we know that, particularly in cities, immediately after an injury, with the first signs of syncope, some sympathetic bystander is pretty sure to dose the patient with alcoholics, and we can see that, as in a case of this kind, when there has been great loss of blood, a small quantity of stimulant may cause great excitement.

It might be asked why we did not do a primary amputation as soon as the man entered the hospital, in order to avoid the dangers of hemorrhage, tetanus, etc. We did not for two or three good reasons. The first was because the patient would not then consent to the operation, and the next was that he was in such a state of collapse at that time that, even though there were no objection, we would decline radical measures. Exclusive of these reasons, primary amputations are now almost never resorted to in this hospital. By delay in railroad injuries of a limb, in children particularly and in the young, we can always better appreciate just how much must be sacrificed. Indeed, in not a few cases that have at first presented but a gloomy aspect the circulation has in time become reëstablished; what has at first seemed a hopelessly destroyed limb has been saved.

In railroad disorganization of a limb it is important to note that the same agency that effects the local disorganization, by its sudden, violent concussive force, also conveys a great shock to the nerve-centers or the fixed glands, so that even though our patient should safely survive amputation, other complications may arise that may invalid the patient, and though the amputation do well our patient may suddenly succumb after reaction has set in.

As to the technique of amputation, I would say that there are two points, mainly, that should always be observed, viz., to spare as much bone as possible, and so to form your flaps that they maintain their vitality until healing is complete. The usual rules set down in the text-books have but little application in amputation for traumatisms.

Our next patient comes to us with a fistula in ano. He is a man, thirty-seven years old, who always enjoyed good health until six months ago, when he commenced to suffer from piles. These were later followed by a perineal abscess, which was opened and evacuated one month ago. Since then he has had a fistula. He says that no wind or feces escape through it, and on examination with a probe and by injection no internal opening can be found in the bowel; hence we must assume that he has what is known as an incomplete external fistula. This is a good case to demonstrate how easily and safely these cases can be operated on by the employment of cocaine. It greatly simplifies the operation, so that practically no assistants are needed, the patient himself holding the buttocks apart, while the cocaine solution—no stronger than one per cent.—is injected in a radiating direction into and through the sphincter. Now the sphincter is widely dilated, the parts cleansed, and the mucous membrane mopped with the same solution, and we are ready to cut; this, you see, is accomplished without pain or inconvenience. The parts are now flushed and cleansed, the man gets up and walks into the ward, rests an hour, and goes home.

Here are two cases of peritonitis—one coming on two weeks ago, the man having been run over. There was evidence of hemorrhage into the cavity of the peritoneum. Rest, inunction of mercury, opium internally, with hot topical applications, have set him right again, and he goes out to-morrow. The other case is evidently of appendicular variety, and was sent in to me for laparotomy and appendisectomy. We did not regard an operation as necessary. Our line of treatment was essentially the same as in the other case. The man, as you see, is as spry as a kitten. He goes home to-day, after having been in the hospital just eight days.

CLINICAL MEMORANDA.

OVARIAN CYST IN A GIRL TWELVE YEARS OF AGE.

BY CHARLES F. DAVIDSON, M.D.,
OF QUEENSTOWN, MD.

ON January 5, 1892, I was called to M. H., who, her mother told me, "had a lump in her stomach." The girl was born May 19, 1880, and was, therefore, nearly twelve years old. She had never menstruated; was fairly well-developed; in good health; and had always been in good health. The mother had noticed the "lump" two weeks previously, and, as the patient had suffered with nausea, sometimes with vomiting, the mother had become alarmed, and consulted me. On examination I found an enlargement in the lower part of the abdomen, in the middle line, just above the pubic arch. To the hand it conveyed the sensation and was about the size of a gravid uterus at about four and a half months. The vagina was large for a child of her age; the cervix uteri was long. I suspected pregnancy, and gave a tonic as a placebo, and directed the patient to take plenty of out-door exercise. I saw her several times in the course of the following week, without being able to determine the exact nature of things. On January 21st I gave her chloroform, and made a thorough examination. I found that the lump was rapidly increasing in size, and that the patient had begun to lose flesh. I now excluded pregnancy, and diagnosticated ovarian tumor. On account of the rareness of ovarian growths in the young, on January 22d I took Dr. Corkran, of Centreville, Md., to examine the case with me. After a careful examination, under chloroform, he concurred in my diagnosis, and we advised an operation at once. After thinking the matter over for twenty-four hours, her parents—illiterate persons—refused to allow of operative interference, saying that they would rather the child should die. The tumor steadily increased,

and, by February 27th, entirely filled up the lower part of the abdomen. Cough became most distressing, and the lower limbs much swollen. On March 19th the girl died, being just eleven years and ten months old.

I requested and obtained permission to make a post-mortem examination. On opening the abdomen I found a multilocular ovarian cyst, firmly adherent to the peritoneum. Introducing a trocar I drew off about a gallon of fluid of the consistence of syrup. On account of the firm adhesions, the tumor was with great difficulty removed. It had a pedicle, about two inches long, originating from the right ovary, the left ovary and uterus being perfectly normal. The small intestine for a distance of eight inches was bound to the upper surface of the cyst by firm adhesions. I punctured several more cysts, and collected another gallon of fluid of the same sort as that found in the cyst first punctured; then the solid part of the tumor weighed twenty and a quarter pounds. All of the other organs were normal, except the spleen, which was very soft.

The case reported is particularly interesting for two reasons: First, the age of the patient, and, second, the very rapid growth of the tumor.

Scanzoni records 97 cases, of which 70 were from eighteen to forty years old; Chéreau, 230 cases, of which 133 were from seventeen to thirty-seven years old; Lee, 135 cases, of which 82 were from twenty to forty years old. Of Scanzoni's, 5 were between fifty-five and sixty.

In the *Medical Press and Circular* for March 26, 1873, a case is reported in which ovariotomy was successfully performed on a child six years old.

Mr. Safford Lee collected statistics as to the duration of the disease in 123 cases not subject to curative surgical treatment: In 38 the duration was one year; in 25, two years; in 17, three years; in 10, four years; in 4, five years; in 5, six years; in 4, seven years; in 3, eight years; in 17, from nine to fifty years.

Judging from the increase in the size of the tumor after I saw it, it could not have been growing more than six weeks previously; the patient died in less than eleven weeks after I first saw her. I have not found a case in the literature of the subject that pursued so rapid a course. As for the age of my patient, there have been cases as young or younger, but they are exceedingly rare.

A FATAL CASE OF THROMBOSIS OF THE LEFT MIDDLE CEREBRAL ARTERY.

BY EDWARD A. BALLOCH, M.D.,
OF WASHINGTON, D. C.

AT half-past one on the morning of April 18th I was hurriedly called to Mrs. C., a widow, white, sixty-five years of age. When I reached the house I found her *in articulo mortis*, and she died within three minutes after my arrival.

Upon inquiry, I learned that she had always been a healthy, vigorous woman, but that for the last five or six years she had frequently experienced a sense of numbness in the right hand and arm, and some confusion of sight in one eye (which one I could not definitely ascertain).

On the day preceding her death she had seemed more than ordinarily cheerful and strong, and had gone to church three times. Sometime after midnight, her granddaughter, a child of twelve, who slept in the same room with her, was awakened by an inarticulate sound emanating from the throat of her grandmother. The child screamed and aroused the family. When they reached the room Mrs. C. was found to have vomited freely and to be unconscious. The stupor continued until death.

I also learned that the mother of the deceased had died from "paralysis," after an illness of three days. One son presents an arrest of development in the left arm, due to paralysis occurring when he was six months of age.

An autopsy was performed April 18th, 11 A.M., ten hours after death, by Dr. D. S. Lamb. Fluid was found in both pleural cavities, and there was moderate edema of the lungs. The heart was normal as to size, thickness of walls, and condition of valves. The abdominal viscera were normal, the stomach being perfectly empty. The dura mater was adherent to the skull-cap. The pia and arachnoid were injected. The choroid plexus was the seat of large cysts. The arteries at the base of the brain were extensively atheromatous. In the left Sylvian artery was found a firm, red clot, completely plugging the vessel for one-third of an inch beyond its origin. The pons and medulla were normal.

Remarks.—Death from thrombosis of the Sylvian branch of the middle cerebral artery is not common. The anastomoses between it and the other cerebral vessels are usually so free as to allow of the ready establishment of the collateral circulation. In this case the probable explanation of the fatal termination is as follows: After a day of more than usual excitement and action, there was at night a corresponding reaction and relaxation of the vital forces. The circulation became sluggish and stagnation occurred in the atheromatous and narrowed vessel, and the heart had not force enough to drive sufficient blood through the remaining vessels, which were diseased and lessened in caliber, and death accordingly resulted from acute anemia of the brain. The pulmonary edema was coincident and passive only.

EXPULSION OF A GALL-STONE OF GREAT SIZE.

BY P. C. WILLIAMS, M.D.,
OF BALTIMORE, MD.

EARLY in March of this year (1892) I was called to see an old lady, seventy-two years old, who was suffering from an attack of cholera morbus, caused by imprudence in diet. The pain and diarrhea were soon relieved, but the vomiting persisted. After a few days the old lady vomited fecal matter in great abundance. This, of course, led me to suspect intestinal obstruction, and after careful investigation I discovered in the ileo-cecal region a well-defined oval tumor, about two inches in diameter. I inferred that this tumor was an intussusception of the bowel produced by the prolonged vomiting.

On several occasions I had relieved cases of intussusception by giving large doses of chloral, and keeping the patient profoundly under its influence for from thirty-six to forty-eight hours, during which time the constriction of the bowel became relaxed, and the intussusception

was relieved. Recalling these cases, I gave large doses of chloral and morphine, which were promptly vomited. I then administered an enema of thirty grains of chloral, and two drams of fluid extract of senna every two hours.

This treatment produced profound sleep, and at the end of thirty-six hours my patient was relieved by the passage of an immense gall-stone per rectum. The stone was a *smooth cylinder, one inch and five-eighths long*, with a diameter of *one inch and one-eighth*, and a circumference of *three inches and five-eighths*. Both extremities of the cylinder were smooth and spherical.

After the passage of this stone the old lady rapidly recovered her health, and is now better than she has been for several years. This case and its fortunate termination were of great interest to me.

Upon inquiry I ascertained that last July (1891) this lady had a very severe illness at Atlantic City, which was thought to be due to peritonitis. From this attack she slowly recovered, but continued in delicate health until she came under my care for the first time last December (1891) with an attack of "grippe." She soon rallied from the "grippe," and in March (1892) again came under my care as described.

I have no doubt that during her illness at Atlantic City the gall-stone found its way by ulceration of the gall-bladder into the intestine, and gradually passed down without special symptoms until it reached the ileo-cecal valve, where it was arrested and caused the fecal vomiting that disclosed the true nature of her sickness.

The points of special interest in this case were: First, the great size of the stone—the largest I ever saw; second, its prompt and safe expulsion through the valve under the prolonged use of large doses of chloral and senna.

THERAPEUTIC NOTES.

Paralytic Obstruction of the Intestine Relieved by the Constant Current.—SEMMOLA (*Internationale klin. Rundschau*, 1892, No. 16, p. 641) has reported the case of a man, twenty years old, of nervous temperament, in whom, after the occurrence of diarrhea, symptoms of intestinal obstruction appeared; to these ischuria was added. Ordinary treatment was without avail, and celiotomy was proposed. From the suddenness of onset of the symptoms of obstruction after the occurrence of diarrhea; from the paroxysmal character of the pain; from the coëxistence of paralysis of the bladder, without previous disease; and from the neuropathic tendency of the patient, a diagnosis of paralysis of the bowel was made, and the application of the constant current was recommended. The positive pole, attached to a catheter, was introduced into the rectum, and the negative pole stroked upon the abdomen in the course of the colon. The applications were made for from eight to ten minutes thrice daily. The symptoms gradually improved, and, after the ninth application, the bowels were spontaneously moved. In the course of ten days the patient was completely restored to health.

The Treatment of Pneumonia.—From an extensive study of the mortality of pneumonia under different modes of treatment, REED (*Therapeutic Gazette*, Nos. 3 and 4, 1892) concludes that water, locally applied, either as the wet-pack or as the bath after the method of Brand, is the most efficient single therapeutic measure for acute pneumonia. In the first stage of the disease, veratrum viride or aconite can accomplish more than any other drug; and in the second stage the same is true of digitalis. A combination of one of these cardiac sedatives with opium and diaphoretics constitutes a safe and successful internal treatment in the first stage, being capable of aborting the disease if the administration is begun near the onset and is repeated at short intervals, day and night. Venesection, though a most efficient procedure in the treatment of pneumonia of sthenic type and, judiciously employed, considerably more successful than expectant measures, is no longer an indispensable resource in managing the disease, as other remedies have been found to accomplish the same results more surely and more pleasantly.

Radical Treatment of Dacryocystitis.—GUAITA (*Centralbl. für prakt. Augenheilk.*, No. 1) recommends curetting the lachrymal canal and the introduction of a decalcified bone tube into the duct previously divided, for the relief of dacryocystitis. The tubes are prepared from the bones of the hind-legs of large turtles; the bones are treated with dilute hydrochloric acid, and the medullary cavity cleansed; the tubes are kept in absolute alcohol and a solution of mercuric chloride, 1 : 500. They should average about an inch in length, and from a tenth to an eighth of an inch in diameter. After the lachrymal canal is opened and curetted, it is cleansed with gauze saturated with a solution of mercuric chloride, 1 : 2000; the tube is introduced, and the wound is closed with one or two sutures. A compress wet with a cold solution of mercuric chloride is afterward applied. Unless severe inflammatory symptoms be present, a cure can be expected in from four to six days.—*Wiener medizin. Presse*, 1892, No. 15, p. 594.

The Treatment of Pleurisy —In a communication to the French Academy of Medicine, WEST (*Bull. de l'Acad. de Méd.*, xxvii, 3, 14, p. 484) states that pleurisy purulent from the outset is much more common in children less than twelve years old than in adults. If in a case of frank pleurisy with effusion absorption has not begun in the course of eight days, puncture ought to be made. In a large number of cases of purulent pleurisy in children, a single puncture suffices, if care be taken to prevent the entrance of air and if the wound be hermetically closed. It is scarcely possible to puncture too early.

Atropine as a Hemostatic.—DMITRIEFF (*Wratsch*, 1891, No. 50) reports the successful employment of atropine as a hemostatic in two cases of metrorrhagia. In one case the hemorrhage persisted, despite the employment of the usual remedies, including the tampon; but ceased after four injections each of gr. $\frac{1}{24}$ of atropine. The second case occurred in an anemic woman, who became syncopal, with cold extremities. The first injection was followed by improvement, and the third by cessation of the bleeding. In both cases the pupils were slightly dilated.—*Wiener medizin. Presse*, 1892, No. 16, p. 639.

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SATURDAY, JULY 2, 1892.

THE PULMONARY COMPLICATIONS OF INFLUENZA.

AMONG the recent valuable contributions to the subject of influenza is a lecture upon the pulmonary complications of the disease, delivered at the Pennsylvania Hospital, by PROFESSOR DA COSTA.[1] The paper is the more valuable because the author's experience with the disease is not confined to recent years. He calls especial attention to the great variation in type of the respiratory disorders encountered in different epidemics, and to the not inconsiderable variation even among the cases met with during any one epidemic.

While in some previous epidemics there was observed merely a catarrh affecting the upper air-passages, with laryngeal and bronchial involvement, but with little tendency to spread to the deeper parts of the lungs, the recent visitations have been characterized by the tendency of the morbid process to affect the pulmonary parenchyma. The chief pulmonary complication of influenza in the recent epidemics, as illustrated by a typical case exhibited by PROFESSOR DA COSTA, was an intense congestion, often, though wrongly, called pneumonia. With rapid breathing, harassing cough, and evident oppression, there was found slight impairment of percussion-resonance at the lower part of the chest, especially posteriorly, and frequently the more marked on one side, but without decided dulness or evidence of consolidation. The breath-sounds at the lower part of the chest were feeble and ill-defined. There were numerous fine râles. The expectoration was rather tenacious, but not decidedly viscid, and not rusty.

The attack often began, as does true pneumonia, with chill or chilly sensations, which might occur early in the course of the influenza, or some days after the ordinary symptoms of the latter had been manifested. The fever subsided gradually and regularly, or gradually and irregularly, and but rarely by crisis. Crises, however, did occur exceptionally, and DR. DA COSTA reports a striking instance.

The cardiac complications added to the embarrassment of the circulation. The heart was quick, feeble, and irregular. Short systolic apex-murmurs were not uncommon, but much more general were a defective first sound and a sharp second sound. Sudden movement involved the danger of fatal syncope. A case is reported in which death resulted during an attempt of the patient to raise himself to use a bedpan. The autopsy showed a white clot, evidently ante-mortem, in the right side of the heart, extending from the auricle into the ventricle. The left chambers were empty and contracted. To the eye the muscular structure appeared normal.

The most prominent nervous phenomena were insomnia and delirium. To the latter, DA COSTA gives the name of "business delirium," because the patient's mind persistently dwells upon his ordinary occupations. This type of delirium was noticed more particularly in professional and business men. In many cases, especially in the graver, albuminuria, associated with the presence of tube-casts and other signs of actual renal involvement, was observed. The albuminuria was not persistent, but passed away with the attack. It was found in cases without delirium, and delirium was observed without the occurrence of albuminuria.

DA COSTA believes "that we are wrong in combining the statistics of 'influenza lungs' with those of pneumonia; that we are wrong in basing our treatment upon the view of their identity; and that we are doubly wrong in deciding against the value of remedies which we have learned to depend upon in ordinary pneumonia, because they may fail us in the lung disorders of influenza."

[1] International Clinica, vol. ii, second series, reprint.

It is true that there are cases in which, after death, are found appearances indicative of true croupous pneumonia, but these are comparatively rare, and the author, while he does not express a positive opinion, seems inclined to look upon the pneumonia as an epiphenomenon rather than as an essential element of the disease. Among the cases that he reports is one of croupous pneumonia following influenza, in which death resulted from pulmonary edema.

The treatment upon which PROFESSOR DA COSTA particularly relied consisted chiefly in the administration of large doses of ammonium salts, with quinine, with most carefully sustained nutrition, and in many cases with digitalis and with stimulants. Absolute rest was insisted upon; the patients were even made to take their medicine from a tube, to avoid the danger of sudden heart-failure from the exertion of rising. Digitalis is a remedy often used in a routine manner, and thus much abused; nevertheless, properly watched and used intelligently, the author attributes much value to it. Strophanthus was sometimes used in cases in which digitalis did not seem to be well borne, and strychnine was given in alternation with digitalis, or alone. In all cases in elderly persons, with atheromatous vessels, strychnine is a safer remedy than digitalis, for the latter so increases arterial tension that in one instance the brittle vessels gave way and an extensive cerebral hemorrhage resulted. Potassium iodide was disappointing, so far as any effect upon the pulmonary conditions was concerned, but DR. DA COSTA believes that ammonium iodide is worthy of large trial. Except in instances of great prostration, extensive dry-cupping was extremely useful. Poulticing or wrapping the chest in huge layers of wool and cotton renders the patient uncomfortable and hot to an extraordinary degree, interferes with examination of the chest, and exerts no beneficial influence. Only in instances complicated by pleurisy, or in lingering consolidations, would the author recommend the use of poultices.

Bleeding may produce some amelioration of symptoms in certain cases, but exerts no remedial influence. Oxygen likewise seemed to DR. DA COSTA to be devoid of curative effect, though possessed of palliative virtue. Many cases recovered without the use of alcohol; on the other hand, alcohol was often used freely, and seemed especially useful in cases complicated by true lobar pneumonia.

Nitro-glycerin was beneficial in cases in which the element of congestion was marked. Strophanthus was used coincidentally to steady the heart. Of hypnotics, paraldehyde, sulphonal, and hyoscine were the most dependable, hyoscine being the best of these.

In cases with rapidly extending bronchitis and edema, no certain treatment could be depended upon, yet a case is related in which recovery took place notwithstanding the desperate nature of the symptoms. So far as treatment may have influenced this case, recovery seemed to be due to persistent dry cupping and the free administration of ammonium salts, quinine, strychnine, and stimulants.

Not the least element of value in the observations of DR. DA COSTA, here abstracted, is their judicial tone. Representing the matured conclusions of an unusually well-qualified observer upon matters concerning which considerable differences of opinion have been expressed, they are of permanent importance, and THE NEWS has, therefore, so far departed from its custom as to present them in this column.

IMPOTENCE.

THE NEWS has received a letter from an individual who signs himself "A Sufferer," who inquires "for a friend," if impotence is curable, and if the confident claims of the quack circular are to be looked upon as eternal truths.

This communication brings to mind a large class of patients difficult of treatment, and we cannot help feeling that many of them wander off to quacks because of lack of improvement at the hands of the general practitioner, who is too likely to rely on the oracular utterances of the clinical index, and settle on the routine of sexual stimulation as the proper course to pursue.

The causes of impotence are almost as many as the causes of ill-temper, and the treatment must be suited to each particular case. In view of the fact that in a recent work on circumcision the author confuses impotence and sterility, it may not be unprofitable to discuss the modern views upon these subjects.

By impotence is meant an inability to successfully perform the sexual act. This may result from some congenital malformation, or distortion of the sexual organs, as great hypospadias, absence of the testicles, or excessive brevity of the penis; or some pronounced organic disease, as testicular atrophy, varix

of the dorsal vein of the penis, calcification of the fibrous septa of the penis, etc. All cases belonging in the foregoing class are designated as examples of organic impotence. Many of them are incurable, but some may be relieved by operation.

Impotence may result from a mental condition when the organic apparatus of erection is entirely normal. It may arise from mental preoccupation, exhaustion, worry, personal aversion, bad temper, excessive anxiety to play a creditable part (as on a wedding night), or a fear of failure, and a host of other conditions as various as the emotions of man.

This condition may be occasional or persistent. It is purely a morbid mental state, and treatment to be successful must be directed to the mind. The accidental or occasional cases of psychic impotence need to be reassured, and often given a placebo. The persistent cases require very careful guidance. JOHN HUNTER had a patient, recently married, who was unable to have an erection. HUNTER gave some indifferent drug, directed the man still to sleep with his wife, but under no circumstances to have intercourse. These instructions were violated almost as soon as given. Again, impotence may be symptomatic of some other diseased state, as opium or chloral eating; bromism, and chronic poisoning by lead, arsenic, and mercury; injuries and diseases of the cerebro-spinal nervous system, as concussion, spinal meningitis, locomotor ataxia, and advanced paresis, and of such conditions as albuminuria and diabetes. In not a few cases of symptomatic, as in other forms of impotence, the loss of power is preceded, and in some cases accompanied by inordinate desire. Its onset is likely to be marked by imperfect erections and premature discharges, and its treatment is that of the causative disease.

An enormous majority of the impotent is composed of those who labor under loss of tone. To the late PROFESSOR S. W. GROSS belongs the credit of conclusively proving that "impotence is generally produced by subacute or chronic inflammation and morbid sensibility of the prostatic urethra, which are frequently associated with stricture, and which are usually due to masturbation, gonorrhea, sexual excess, and constant excitement of the genital organs without gratification of the passions." This irritation of the prostatic urethra overstimulates and exhausts the genito-spinal center in the lumbar cord, the erections become feeble, and the ejaculations premature or belated, and, finally, erection may be impossible, desire may be exaggerated, absent, or perverted; nocturnal seminal emissions or diurnal losses are likely to ensue, and spermatorrhea may develop. There is a whole train of uncertain bodily symptoms. Hypochondria appears, and occasionally insanity.

Proper treatment, if inaugurated before insanity occurs, is almost always successful. Stricture and hyperesthesia are relieved by steel bougies (up to No. 35 French), the meatus often demanding division to admit the larger sizes. In many instances bougies alone remove the chronic inflammation, while in some they relieve, but do not cure. In this last class cold-water currents may be thrown through the return catheter; inunctions of ichthyol and lanolin, or of mercurial ointment, are made to the perineum; blisters are used on the perineum, injections of silver nitrate, or other astringents, are thrown in by the deep-injection apparatus. Seminal losses are controlled by bromides and atropine, with hot hip-baths, hyoscine hydrobromate, or camphor monobromate. After the seminal losses cease, and the hyperesthesia is abolished, it may be necessary to give a tonic course of treatment. Strychnine and dilute phosphoric acid, or strychnine, arsenic, iron, and quinine, may be employed.

We have in the foregoing remarks only hinted at the treatment of these troublesome cases, but we hope that we have shown enough to remind the general practitioner that to cure impotence requires some knowledge and some skill, and a larger armamentarium than a syringe with zinc sulphate and a bottle containing the acid phosphates, or cantharides, or potassium bromide.

SELF-REFUTED.

THE following extract from an editorial article in the *Practitioner's Monthly* for May, 1892, opposing the ground taken by THE NEWS and the American Medical Association against the use of secret nostrums, furnishes so complete a refutation of the other portions of our contemporary's argument, that, despite its numerous misstatements of fact, we cannot refrain from printing it verbatim:

"The arbitrary test proposed by our cotemporary, 'that the full process (of manufacture) is of public record, or the true and exact composition of the finished product is made known,' is palpably absurd, since to do this would give away the secret. Antipyrin is said to be subject to chemical analysis or test. So are phenacetin and sulphonal subject to chemical analysis or test, but how much wiser is anyone as to the process of manu-

facture? Someone gave away the secret of manufacture of acetanilide, and the consequence is that antifebrin has ceased to have a market value. Does any sane man suppose that if the process of manufacture of antipyrin or any of the other of these so-called proprietary preparations were actually known, that they would not be put on the market under another name, the same as acetanilide has? What better illustration is needed than the one just cited of acetanilide, which sells for fifteen cents an ounce, and antifebrin for one dollar?"

What an excellent weapon our opponent has unwittingly placed in our hands!

PRESCRIPTION-WRITING EXTRAORDINARY.

À PROPOS of the interest taken of late by the manufacturers of pharmaceutical preparations in the education of physicians, we beg to call attention to a recent issue by a Philadelphia firm of a *Therapeutic Reference-Book*, which, it must be admitted, contains some valuable information for physicians; but in a section on prescription-writing the author has evidently essayed a department which he should have left untouched, since even the highly valuable aid of abbreviation fails to cover his utter ignorance of the rules of Latin grammar upon which prescription-writing is based. Thus we have the following:

℞.—Potass. Cynanide.
Potass. Brom.
Ext. fl. Pru. Virg.
Syr. Simple et.
Aqua. Dist. q. s.

Again—

℞.—Hydr. Chlor. Mit.
Soda Bicarb.
Pulv. Cinnamom.
Sach. Lact.
Mix et. divide *into* charta*e* No. xii.
S.—One every two hours.

Had the writer been satisfied to put the whole into good English we should not have complained, but the pitiable conglomeration of English and Latin which is placed before the physician with a view to his *instruction* should be exposed. We are not averse to learning from anyone, but we do protest against the confiding physician who happens to be ignorant of Latin being taught stuff, the adoption of which must excite a smile in the well educated apothecary who compounds his prescriptions.

To Relieve Headache.—WEISS' (*Prager med. Wochenschr.*, No. 15, 1892, p. 159) has observed that temporary relief from headache could invariably be afforded by pressure upon the abdomen at a point midway between the umbilicus and the ensiform cartilage, the mechanism of which is thought to be dependent upon compression of the aorta.

SOCIETY PROCEEDINGS.

AMERICAN MEDICAL ASSOCIATION.

Forty-third Annual Session, held at Detroit, June 7, 8, 9, and 10, 1892.

SECTION ON DISEASES OF CHILDREN.

FIRST DAY—JUNE 7TH.

The Chairman, DR. E. F. BRUSH, of Mt. Vernon, N. Y., in opening the session, read a paper on "Scorbutus in Children." He stated that man is the only animal that not only kills his food before eating it, but makes it *absolutely* dead and, if possible, sterilizes it. The chemist of the day would make us believe that man needs for nourishment only so much nitrogenized and so much non-nitrogenized matter; that a little jar of beef-extract is far superior to ten pounds of meat as found in nature; that milk that has been skimmed, dried, powdered, and thoroughly sterilized is preferable in every way to fresh milk from Nature's laboratory. The statement has recently been made that when the chemist had reached his goal, armies would be able to carry in a small vial supplies for several days, instead of the load of meat and bread they are now obliged to carry. The peasant in the famine-stricken countries, the sailor and soldier when deprived of fresh living food, are all subject to scurvy. Dr. Brush expressed the opinion that the constant use of dead food for infants is wrong; patent baby-foods should be absolutely excluded, and the young thus be guarded from many evils. No greater field exists for the pediatrist than the study of infant feeding.

DR. F. S. PARSONS, of Boston, read a paper entitled "Ought Infants to be Washed Immediately after Birth?" He stated that all wild animals wash their young directly after birth. The human mother, however, cannot perform such duties in the manner of the lower animals, whose offspring, moreover, are covered with hair, necessitating simply the drying of a wet surface; but the child with practically no hair on the body is ushered from an aqueous solution at a temperature of about 100° F., to an aërial temperature of from 20° to 30° lower. Apparently to guard against this sudden cold, Nature has placed a sebaceous covering, which, if allowed to remain, would protect the child from the chilling influences of the reduced temperature. Dr. Parsons, however, does not so much object to the washing of the child as to the manner in which it is generally done, and which so often leads to catarrhal troubles, varying from simple snuffles to broncho-pneumonia. He recommends a little skirt with sleeves and hood, made of some soft unirritating material—for example, Canton flannel—in which the infant should be placed, after being quickly rubbed with pure hog's lard. Here it should remain for four or five days, when it would become accustomed to the lowered temperature, and could with much more safety be washed; but as this would not satisfy the average mother, he would advise covering the head and body with lard, then quickly placing the child in a tub of water at about 103° F., there cleaning and washing the body with a soft linen cloth. He has never seen a child so treated suffer from catarrhal troubles in any way.

In the discussion that followed the reading of the paper, DR. ULRICH, of Pennsylvania, stated that he had long been convinced that there was too much washing of young infants; the nurse seems often only to know that the child must be immediately washed and dressed; he thought that the children lived in spite of the nurses. Soap and water would not touch a heavily-coated child; only oil would do this. He would not dress the child until the day after labor. The inevitable flannel bandage, he thought, was generally rolled too tightly, and put on regardless of the weather, in hottest August as in cold December.

DR. PRESBERY, of Taunton, Mass., felt that he would be greatly criticised if he left a child go twenty-four hours without washing; he agreed that infants are too much washed; the sebaceous coat is applied for the protection of the child *in utero*, and is not intended to remain after birth. He would have the child immediately washed and put in dry absorbent material.

DR. BROWN, of Illinois, thought the people of his State would insist on the band as necessary to hold the umbilicus in place, but he used a linen band in summer.

DR. WIRT, of Indiana, put the band on very loosely, and put on as little clothing as would keep the child warm; he would wash the child twice a week, or at most every other day.

DR. BRUSH, of New York, expressed the thought that the child often suffers more than the mother, and that the crying is a provision of Nature to open the lungs, into which, sometimes, some of the amniotic fluid is drawn, causing a bronchitis, which might be charged to the first bath.

DR. PARSONS closed the discussion by adding that he did not so much object to the early washing as to the manner in which it was done. He would have the child washed, say, only once a week, after the initial bath. He did not employ a band of any kind, believing that they often caused hernia; instead he used dry cotton, held in place by adhesive plaster, which could be easily removed, and after that he employed nothing.

DR. W. S. CHRISTOPHER, of Chicago, read a paper on "Starvation-neuroses." He called attention to the important etiologic relation that malnutrition of the tissues generally bears to the development of various functional nervous diseases and the neurotic symptoms that accompany many other pathologic states.

Chorea, convulsions, laryngismus stridulus, various nervous affections of the bladder, and many minor pathologic nervous phenomena are very frequently starvation-neuroses, and are amenable to treatment corrective of defective nutrition. Inherited tendencies and auto-intoxication are frequent etiologic factors in these conditions, but starvation is a still more frequent one.

DR. BROWN, of Indiana, stated that he does not think that the condition is so often one of general malnutrition of the body as one of special nerve malnutrition.

DR. WATSON, of New Jersey, thought that less attention should be paid to medicines and more attention to diet and pure air.

DR. MARTINETTE, of Baltimore, stated that he had never seen the diarrhea of rickets in winter—a fact indicating that so-called rhachitic diarrhea is often due to other causes.

The discussion was closed by DR. CHRISTOPHER, who had stated that he had often seen the diarrhea in winter.

SECOND DAY—JUNE 8TH.

Morning Session.

DR. F. E. WAXHAM, of Chicago, read a "Report of Four Hundred Cases of Intubation." He stated that he felt called upon to report his cases in consequence of the many unfavorable comparisons of intubation with tracheotomy. The results that he has obtained might well make anyone an enthusiastic supporter of the operation. The following is a record of his cases:

	Cases.	Recoveries.	Per cent.
Under one year	12	4	33.33
One year	52	12	23.07
Two years	70	18	25.71
Three "	69	27	39.10
Four "	79	30	37.97
Five "	39	18	46.15
Six "	25	7	28
Seven "	25	10	40
Eight "	10	6	60
Nine "	6	3	50
Ten "	5	2	40
Eleven "	1	1	100
Twelve "	2	0	0
Thirteen years	1	0	0
Fourteen "	1	0	0
Twenty "	1	0	0
Forty-three "	1	1	100
Sixty "	1	0	0
In all	400	139	34.75

The cases all occurred in private practice. In the first 100 cases there were 27 recoveries; in the second, 34 recoveries; in the third, 40 recoveries; and in the fourth, 38 recoveries; the improvement of instruments, improved methods of feeding and management, and the almost universal administration of mercuric chloride after the first 100 cases, undoubtedly accounting for the larger percentage of recoveries. Failure may be ascribed, firstly, to the difficulty of the operation; secondly, to lack of judgment as to size of tube; thirdly, to the fact that patients are allowed to die from obstructions below the tube; and, fourthly, to lack of careful nursing and feeding. In each large city a few specialists should perform this delicate and difficult operation so as to become expert therein; in country practice tracheotomy is advised in its stead. A tube too large to be expelled only invites disaster; the attendant should be instructed to invert the patient in an emergency, when, if the tube is not expelled, the finger should be forcibly pressed against the trachea from below. A hoarse, squeaking cough, or a flapping sound, means membrane below the tube, which should be instantly removed to allow the cast to be coughed up; the patient should be fed in the inclined position; insufficient nourishment is often given. Dr. Waxham has confidence in the steam atomizer, iron, mercuric chloride, and hydrogen dioxide.

DR. HUBBARD, of Ohio, thought that a child having a much greater expiratory than inspiratory power could always expel a tube, but thought that children are sometimes strangled by sucking into the tube disintegrated membrane, or the foam from the use of too concentrated hydrogen dioxide; this latter he had seen.

DR. S. P. DUFFIELD, Health Officer of Detroit, opened

the general discussion on diphtheria by an interesting consideration of the prophylaxis of the disease. He felt that the present mode of quarantine by placarding a house almost useless, as, when the physician was gone, the inmates mingled promiscuously among their neighbors on the street cars, at the grocery, etc. Cities should have cottage-hospitals outside of city limits; say twenty acres should be divided into five acres each for smallpox, diphtheria, typhus, and scarlatina, separated from one another—where the convalescents might enjoy themselves. He would advise small, cheap, two-roomed cottages, where mother and child could be isolated, the city providing provisions and treatment, etc. This he thought the cheapest, as well as the most effective quarantine.

DR. HANNAN, of Hoosac Falls, N. Y., stated that in his city of 8000 inhabitants the little ones of the rich and poor were dying on all sides, the treatment this year seeming to have no effect whatever. Last year the disease was almost harmless, none dying; this year nearly all die. In one house, containing seven children, two took diphtheria: one lived, and one died; the other five, though they mingled every day in their very small house with the sick ones, did not take the disease.

DR. JENNINGS, of Detroit, spoke of the therapeutics of the disease. It is essential first to know what diphthera is. He felt certain that at the outset it was a purely local trouble, followed by marked constitutional symptoms. Local treatment is of the utmost importance, and, if employed early and vigorously pushed, little constitutional treatment would be needed. No remedy is a specific. It does not so much depend on which local antiseptic is used as on the manner in which it is applied. Dr. Jennings believes that spraying is overrated. He would thoroughly flush the nasal cavity and the pharynx, and treat them as any surgically infectious wound that could not be disinfected with a spray. He preferred hydrogen dioxide and mercuric chloride.

DR. BROWN, of Indiana, felt that there was something in one constitution that served as a soil for diphtheria which another lacked.

The discussion was further participated in by DRS. MOSHER, of Kansas City, Mo.; DUNMIRE, of Philadelphia; WHITE, of Indiana; SHAW, of Cincinnati; LONG, of Buffalo; MCDONALD, of Indiana; and DEVENDORF and DOUGLAS, of Detroit.

Afternoon Session.

The Nominating Committee recommended the following as the officers for the ensuing year: *Chairman*, C. G. Jennings, of Detroit, Mich.; *Secretary*, F. S. Parsons, of Northampton, Mass.; *Executive Committee:* W. P. Watson, of New Jersey; W. S. Christopher, of Chicago; and E. F. Brush, of New York, the retiring chairman.

DR. G. N. HIGHLEY, of Pennsylvania, read a paper on "Acute Meningitis, with Special Reference to Its Treatment," in which he strongly urged the abstraction of blood, either by leeches, cupping, or venesection, believing this superior to any drug. The bleeding should be done early, and often enough to relieve the engorgement, even though the ulnar pulse be very weak. He also strongly advised the constant use of cold to the head, and, if necessary, he at times gave morphine and potassium bromide. He reported three cases successfully treated in this way.

DR. W. E. WIRT, of Cleveland, read a paper entitled "Rickets, and the Treatment of Resulting Deformities."

DR. D. R. SHIMWELL, of Philadelphia, read a paper on "The Surgical Aspect of Rickets."

These papers and their discussion brought out the following points: That the most common cause of rickets is malnutrition (not necessarily under-nutrition) and bad hygiene. The claim that rickets is the manifestation of infantile syphilis was not sustained. The treatment advocated was healthy nutrition, strict cleanliness, and outdoor sunshine. For a hand-fed child under one year, fresh milk, with about one-third lime-water or barley-water added; older children might be given cod-liver oil, iron, the hypophosphites, pounded mutton, poached eggs, also galvanism might be used. The surgical methods necessary were also ably brought out in these papers.

THIRD DAY—JUNE 9TH.

DR. ELI H. LONG, of Buffalo, read a paper on the "Physiology of the Respiratory and Circulatory Changes at Birth, Relating to Asphyxia and Its Treatment." The paper was carefully prepared and well given, and contained many points of interest.

DR. A. HAZELWOOD, of Grand Rapids, Mich., read a paper on the "Prevention of Scarlet Fever." He favors the cottage-hospital plan of treatment on a large tract of land outside the city, where mother and child could both go, as the only way to solve the difficulty of isolation.

DR. VAUGHAN, of Ann Arbor, Mich., believes that the scarlatinal microörganism is distributed throughout the individual, and that in all cases the kidneys are affected, as the poison is eliminated by that route. The accumulation of the poison is dangerous to life. Dr. Vaughan employs elaterium and pulvis jalapi compositus. Pilocarpine is seldom to be used on account of the depression to which it gives rise. Hot or dry baths are to be preferred. The premises on which there have been cases of scarlatina should be disinfected with sulphur (three pounds to every thousand cubic feet), and washed with mercuric chloride (1 : 2000). Quoting from memory, Dr. Vaughan gave the following statistics: The average number of deaths from scarlet fever in Michigan was formerly eight hundred per annum; now it is two hundred. Formerly there were ten cases to each outbreak; now there are only two. These changes are largely due to acquired immunity, more thorough disinfection, and isolation.

DR. BRUSH closed the discussion by reading an interesting paper on "Scarlet-fever Contagion."

The meeting was closed by the reading of one of the most interesting papers of the session by DR. W. A. DIXON, of Ripley, Ohio, entitled "The Morbid Proclivities and Retrogressive Tendencies in the Offspring of Mulattoes," in which he contended that the children of mulattoes are the subjects of constitutional diseases to a much greater extent than are those of unmixed blood. Dr. Dixon's paper will be published in a future number of THE NEWS.

SECTION ON MATERIA MEDICA AND PHARMACY.

FIRST DAY—JUNE 7TH.

The Section was called to order by the Chairman, DR. FRANK WOODBURY, of Philadelphia. In the absence

of the Secretary, DR. WHELPLEY, of St. Louis, DR. F. E. STEWART, of Wilmington, Del., was appointed Secretary *pro tem.*

In the address of the CHAIRMAN, attention was directed to the evident disposition of the Association to devote more time to scientific work, and thus greatly increase the usefulness of the sections. A peculiar feature of the Section on Materia Medica and Pharmacy, is that the Association has formally invited the American Pharmaceutical Association to be represented by delegates who shall participate in its scientific work. This recognition of the high standing of representative pharmacists is a just tribute to their professional attainments, and establishes pharmacy as a department of medical science. This is a consummation of immense value to both medicine and pharmacy; and, that we have been able in any way to assist in bringing it about, should be a subject of congratulation. Its consequences upon the development of pharmacy in this country must be great and far-reaching. Biologic chemistry and practical pharmacy are closely related and should be studied together. The present aspect of medicine, speaking from the therapeutic standpoint, is largely chemical, and is mainly based upon chemical ideas. Indeed, we might almost represent health by a very complex chemical formula, graphically written, so as to express exact molecular composition. Various modifications and substitutions may take place, representing departures from the normal, more or less marked and corresponding with certain diseases or diatheses. While the researches of bacteriologists have revealed specific microörganisms characteristic of different infectious diseases, later observations serve to establish the fact that these so-called disease-germs do not so much cause disease directly by their numbers as they do so indirectly by their chemical products, which enter the blood and act as toxic agents. The important relation of pharmacy to medical practice is that it supplies chemical substances capable of acting as antidotes to the poisonous action of these agents.

DR. A. B. PRESCOTT, of the University of Michigan, read a paper on "Caffeine and the Question of its Isomerism." He considered the various caffeine-bearing plants from chemic and physiologic standpoints, and demonstrated that the fact of isomerism had not been established. Caffeine is a substitution-derivative of xanthine, the former being chemically a trimethyl-xanthine. The effects of various beverages from caffeine-bearing plants are modified by the presence of other substances, such as tannin, volatile oil, etc., caffeine not entirely producing the physiologic effects of tea or coffee.

PROF. REMINGTON called attention to the scientific foundation for the custom of simply making an infusion of tea, by which the flavoring substances and caffeine are extracted, leaving the more insoluble tannin behind.

The CHAIRMAN stated that if the statement is to be accepted that theine is different from caffeine, it will be necessary to write "theæ" after caffeine, since much of the supply of caffeine is obtained from damaged tea. Dr. Edward R. Squibb, in a letter some years ago, declared that there was no difference between theine and commercial caffeine, and threw some doubt upon the existence of caffeine, as such, in the living plant. A practical point, showing that tea is prized for something more than its alkaloidal content, lies in the fact that some cheaper grades of tea are richer in caffeine than the higher-priced teas. As regards the difference alleged to exist between the alkaloid derived from tea and that from coffee, it is possible that some of the volatile substances of the tea are not fully separated from the caffeine, and modify its physiologic action; just as piperine may owe much of its stimulating qualities to volatile substances usually associated with it.

In practical medicine, the insolubility of tannin should be remembered, and in making infusions for the astringent effects, as in antimonial poisoning, or for their action on mucous membranes, the tea or coffee should be boiled. On the other hand, when the stimulating effects alone are desired, a rapid infusion is all that is needed.

In the absence of DR. E. L. PATCH, of Boston, his paper on "Examination of Market Fluid Extracts" was read by title.

A paper on "Pharmacy at Health-Resorts," by DR. F. E. STEWART, was also read by title.

PROF. JOSEPH REMINGTON, of Philadelphia, read a paper entitled "Prescription Exigencies," which was highly practical and interesting, and led to a general discussion.

SECOND DAY—JUNE 8TH.

The discussion on the Revision of the United States Pharmacopeia was opened by PROF. JOSEPH REMINGTON, of Philadelphia, a member of the Committee on Revision. He stated that the Pharmacopeia is rapidly approaching completion and that much of it is already in type. It is believed that the work will appear before the end of this year. Some important changes have been made, the most notable being the adoption of the metric system in the formulæ. The hope was expressed that this change would be approved and supported by the members of the Section.

A general discussion followed, in which PROFS. PRESCOTT, BEDFORD, LONG, DR. CLARKE and others participated.

The CHAIRMAN opened the discussion on "An International Pharmacopeia." He stated that the adoption of an international pharmacopeia has been under consideration for a number of years. The present seems a particularly propitious time for renewing the agitation. Americans read English and Continental medical journals and books, and extracts from these, containing formulæ, are constantly reappearing in American journals and text-books. As there are marked differences in strength among different products bearing the same name (such as tincture of belladonna), and as even the ounce of water is not the same in the British and United States Pharmacopeias, an international comparative commentary upon the different pharmacopeias, containing the principal drugs in use by civilized nations, with their preparations, seems necessary. Such a work would be most convenient for reference, both for physician and pharmacist.

A series of resolutions was offered thanking the Committee on Revision for their valuable labors upon the Pharmacopeia, and requesting that in all doubtful questions coming up for decision preference should be given to those that would facilitate the creation of an inter-

national pharmacopeia. The resolutions were unanimously adopted. The subject was approved and made the order for discussion upon the second day of the session at the next meeting.

THIRD DAY—JUNE 9TH.

The following papers were read by title: "Europhen," by DR. J. V. SHOEMAKER, of Philadelphia; "Tablet Triturates and Dosimetric Granules," by DR. WM. F. WAUGH, of Philadelphia; and "Notes on Therapeutic Novelties," by DR. I. N. LOVE, of St. Louis.

The Business Committee of the Section was elected as follows: Dr. Horatio C. Wood, of Philadelphia; Dr. F. E. Stewart, of Wilmington, Del.; and the Chairman of the Section.

Dr. F. Woodbury was reëlected *Chairman*, and Dr. F. E. Stewart was elected *Secretary*.

SECTION ON PHYSIOLOGY AND DIETETICS.

FIRST DAY—JUNE 7TH.

An anticipated projection of illustrations of foods on the screen, by the Secretary, was postponed owing to the lack of solar light.

It was next moved and seconded that the sense of the Section should be formally passed upon the pending bill in Congress on "Food and Drug Adulterations," following a discussion by a more general meeting, and if possible the officers of the Association to be present.

SECOND DAY—JUNE 8TH.

PROF. C. H. A. KLEINSCHMIDT, of Washington, D. C., Chairman of the Section, read an important paper on the past year's progress in the "Physiology of the Nervous Centers." This lengthy *résumé* included the results of the more recent work, pathologic and clinical, done by European and American investigators. It considered the advances in the anatomy of the origin of the cranial nerves, the discovery of new reflexes and functions of facial motor nerves, the belief now of physiologists that all nerves are trophic, Courmount's theories regarding the functions of the cerebellum, and Richardson's theories, the chemico-physiologic theories of combustion, the action of the central nervous system.

The attractive theory of Pryor, that sleep is due more or less to a decline of destructive metabolism, received full mention, and that clinically insomnia is best treated by restoration of the balance of proper nutrition of the nerve-centers. The many recent advances in cranial-nerve origins is vastly modifying former views of the functions of the bulbar bodies, nerves of sight, and the motor nerves of the face.

The phrenic nerve is now found to be, not a purely motor nerve, but a mixed nerve; and the cervical and spinal sympathetic systems of nerves contain trophic fibers. In fact, it may be said that physiologists are coming to the view that nerve-structures and nerves cannot be so sharply divided into motor and sensory as formerly, but that all nerves are trophic and capable of both motor and sensory functions.

Brain-localizations and the progress made by Horsley and Schaefer, leading uniformly to like conclusions, were noted.

Brown-Séquard's observation that analgesic effects can be produced on wounds in any part of the body (in dogs and monkeys) lasting some days, by stimulating the laryngeal mucosa, was mentioned as being of possible clinical use in the case of man.

Among the new reflexes is one by Knapp, whereby stimulation of the back of the wrist is attended with contraction of the levator menti of the same side.

The vomiting center is proved to be located in a space five millimeters in front of the calamus scriptorius and in the deeper part of the medulla. This fact must dispose of many old theories, and demonstrates that most nerves are capable of many functions, for in this case it is merely the respiratory center acting as a vomiting center.

Among the many new and startling theories must be mentioned that of Courmount on the functions of the cerebellum. This is based upon clinical observations purely, and has attracted the great and favorable interest of Forel, who has twice recently reviewed it. This theory throws much doubt upon our former belief that the cerebellum is simply an organ of coördination. Courmount credits it with other and more important functions, upon the clinical evidence alone.

Mendel's work on the facial nerve-supply must in time undermine most of the present conceptions of facial innervation and functions of important organs.

All action of the central nervous system, according to Richardson, is due to chemico-physiologic action or "combustion"—(*a*) the slow combustion in the cerebro-spinal axis, and (*b*) the more obvious combustion in the so-called working organs represented by animal heat. The gray matter is the seat of a slow combustion, and the white matter supplies the combustion-material. The cerebro-spinal fluid has the most important function, because it is the most condensed fluid of the cerebro-spinal axis, which is not only the center for the reception of external impressions, but a true chemical and dialyzing center and the center of static combustion.

SURGEON C. A. SIEGFRIED, United States Navy, read a paper on "The United States Navy Ration," giving the history of the food-supplies and methods in use from revolutionary times to the present, the various exigencies and requirements of naval seamen's dietaries, the character of their muscular work, and the nutrient and dynamic values of the present navy rations. The scales of food-supplies included that for naval apprentices, the regular seamen, and the punishment diets. He would divide a ship's dietary into the three classes of moderate workers, hard workers, and severely hard workers, the latter to receive as much as 210 grams of protein, 175 of fat, and 650 of carbohydrates; and the other extreme, the moderate workers, Prof. Atwater's scale (or standard American) of 125 grams each of protein and fat and 500 of carbohydrates. The average modern war-ship's company is composed of 10 per cent. moderate workers, 65 per cent. hard workers, and 25 per cent. severely hard workers—firemen, etc. Greater satisfaction could probably be secured in naval rationing if the common adaptations and economic methods in use in some foreign navies were applied in ours, and the food-supply were graded according to work, climate, season, etc. On the whole, the United States Naval ration, while superior to any other naval ration in dynamic or potential energies, is still below that of the well-paid mechanic or laborer ashore, and could be easily improved upon. The common

experiences the world over exist in the navy regarding waste in preparation and cooking, and no more or greater service could be done "Jack" than by training for him competent cooks. The United States Navy ration is commuted at thirty cents per diem, and the boys coming into the service are subsisted by purchase, and consume about 18 per cent. more nutrients for this sum than can be calculated for the regular ration issues. The paper contained many tables of obvious value, the fruits of long labor.

The paper on "The Army Ration," by ASSISTANT SURGEON CHARLES E. WOODRUFF was, in the absence of the writer, read by the Secretary of the Section. It was a long and painstaking review of the present customs in the army, the many difficulties and trials under which army authorities work, and a detailed analysis of the food-supplies consumed by a body of troops at a Western outpost for a period of ten days. There has not been much change in the army ration for many years, and in the absence of careful company and commanding officers the soldiers may at times lack a proper or varied enough dietary. These defects are remedied in most cases, however, by good management, company gardens, and efforts in the direction of good cooking. A garrison post may, in the instance of a desert or barren location, be poorly nourished, and in another luxuriously, owing to the possibilities of a good garden. It is, however, plain that something could be done both for our soldiers and sailors, notwithstanding that in recent years much improvement has been made in their food-supplies. This contribution should be put in the hands of every army officer, containing, as it does, so much of valuable and pertinent detail of actual customs, and the ways and obvious means so clearly pointed out for their improvement.

The Association has thus, in permanent form, full and detailed information regarding the subject of dietetics of our army and navy, and the scientific data concerned, in the most satisfactory manner.

"The Methods, Quality, and Quantity of the Component Parts of the Marine-Hospital Service Food-supplies" were given in a paper by Dr. G. W. STONER, but these, being ample and the common daily marketings and of fresh supplies, call for no extended notice.

THIRD DAY—JUNE 9TH.

The subject of the Paddock "Food and Drug Adulteration Bill" was taken up, and, being discussed, was most heartily recommended for enactment as being of vital importance to the health and well-being of our people.

The subject was transmitted to the Section on Materia Medica and Pharmacy for consideration.

The following papers were read by title, the writers not being present:

"Diet in Its Relation to the Treatment and Prevention of Disease," by Augustus P. Clarke, Cambridge, Mass.; "The Relative Interdependence of Organs in Health and Disease," by H. J. Herrick, Cleveland, Ohio; "Food and Hygiene of Old Age." by J. M. French, Milford, Mass.

Obituary.—Sir Wm. Aitken, Professor of Pathology in the Army Medical School at Netley, is dead, at the age of sixty-seven years.

AMERICAN LARYNGOLOGICAL ASSOCIATION.

Fourteenth Annual Meeting, held at Boston, Mass., June 20, 21, and 22, 1892.

DR. S. W. LANGMAID, of Boston, delivered the President's Address. He made touching reference to the loss of Dr. Donaldson, of Baltimore, and of Sir Morell Mackenzie—the former a Fellow, the latter an Honorary Fellow, of the Association. He reviewed the rapid advance made in laryngology within a few years, since it took a prominent position among the specialties in medicine. Such advance will be greatly helped by faithful adherence to this Association. Companionship with fellow-workers is necessary to completeness of one's growth. Membership is not only a means of information, but it also acts as a stimulus to work. Dr. Langmaid expressed the hope that the next ten years will show such work that American laryngology will occupy the position that has always been accorded it, namely, the first in merit as well as priority of establishment.

DR. D. BRYSON DELAVAN, of New York, read a paper on "The Influence of Certain Diathetic Conditions upon the Prognosis in Operations upon the Throat." He called attention to the importance, before operating upon the throat, of searching for the existence of a diathetic condition that might influence the result of the operation, such as the strumous, the rheumatic, and the hemorrhagic, and exophthalmic goiter, and general lymphadenoma. In the case of the two last mentioned, the removal of enlarged tonsils and of adenoid hypertrophy at the vault of the pharynx is attended with no extraordinary risk.

In strumous cases, complete removal of the offending tissue is more difficult, recovery is slower, and recurrence is more probable. The earlier, however, the cases are operated upon the better.

In rheumatic cases no special difficulties are offered, and the prognosis is most brilliant.

The hemorrhagic diathesis is the most important, because the most dangerous. Its presence contra-indicates all surgical interference. The only known accidents that have happened in this country in the removal of adenoid hypertrophy at the vault of the pharynx have been in hemophilic subjects. Adenoid enlargements are unusually common in these patients. There is no method of operating upon them, now known, that is safe. The galvano-cautery is not a reliable hemostatic, even in ordinary cases, as bleeding, both immediate and secondary, may occur after its use. As many of these cases urgently require relief for their throat-troubles, it is most desirable that a method of reaching them more satisfactory than any heretofore practised be devised.

DR. S. HARTWELL CHAPMAN, of New Haven, read a paper entitled "Some Pathological Conditions of the Upper Air-passages Coincident with Attacks of 'La Grippe.'" He reported sixteen cases of more than ordinary interest, selected from a large number of cases of influenza complicated by secondary affections of the upper air-passages. Eight were cases of spinal disease; one, a case of diabetes insipidus; four, cases of renal disease; three, cases of rheumatic gout.

The onset of "la grippe" was quite similar in all

of these cases: headache, nausea, anorexia, flying pains, exhaustion, progressing to extreme malaise; moderate fever, pulse either considerably accelerated or greatly retarded, mild delirium, pain and stiffness in the back. There is a close similarity between these symptoms and those of the milder forms of epidemic cerebro-spinal meningitis.

One of the rheumatic cases presented laryngitis crouposa, complicated by broncho-pneumonia; two, aphthæ of the mouth and pharynx, extending to the brim of the larynx.

The four cases of renal disease presented sanguineo-purulent naso-pharyngeal inflammation, associated with acute tonsillitis and sympathetic enlargement of the cervical glands. The swelling of the tonsils became so great as to threaten suffocation, and was relieved by incision.

In some of them there was hemorrhage, but not of dangerous character; in one, croupous laryngitis. The duration of the naso-pharyngeal inflammation was about two months; of the laryngitis, only four days.

In the case of diabetes, there was intense congestion of the entire pharynx and edema of the larynx, which continued for eight days and markedly interfered with breathing. During the severest period of the disease the pulse, which previously had been frequent, fell to 70, and the patient was less nervous.

In one of the eight cases of spinal disease, with kyphosis, a form of paralysis developed that had been absent for many years; and during the attack the pulse, normally 80, was reduced to 50. The spinous processes were intensely sensitive. In three cases of curvature of the spine in females the attack of influenza was not severe; but in all there was reduction in the rate of the pulse, extreme malaise, and sensitiveness of the spine. Secondary affections were aphonia and purulent naso-pharyngeal inflammation.

DR. FREDERICK I. KNIGHT, of Boston, read a paper on "Pharyngo-mycosis." Ever since special attention has been paid to disease of the throat, he said, observers have been struck by the peculiar obstinacy of chronic follicultis of the tonsils, not infrequently accompanied by a similar condition at the base of the tongue, and occasionally on the arches of the palate and of the pharynx. The affection presented whitish, yellowish or grayish exudations situated at the mouths of the follicles, sometimes cheesy and easily removed, sometimes cretaceous, and sometimes only tough and stringy, and running deeply into the follicles. Speedy recurrence follows removal of the products, even after the subsequent application of strong medicaments. Fraenkel, in 1873, pointed out an abundance of leptothrix threads in such products, and some writers have looked upon the parasite as the cause of the condition. A number of other forms of parasitic growths in the throat have also been described. Other observers, notably Chiari, believed that the parasite is simply an accidental complication.

In the treatment of typical cases of mycosis nothing has been found satisfactory except boring deeply into each follicle with a galvano-cautery point. If any of the disease were situated in a part of the tonsil that could be removed, excision would shorten the treatment.

DR. DELAVAN stated that he had obtained the best results from frequent washing with borax or with mercuric chloride, and, above all, by correcting disturbed digestion.

DR. DEBLOIS, of Boston, stated that he uses instrumental means, and a mild astringent, such as nitrate of silver, and gives attention to the digestion.

DR. JOHNSON, of Baltimore, stated that he found these cases mostly among debilitated school-children and old subjects. He uses local and constitutional measures.

DR. CHAPMAN advised treating these cases locally, with fuming nitric acid, introduced through a grooved platinum needle, and internally by nitro-muriatic acid.

DR. JONATHAN WRIGHT, of Brooklyn, reported "A Case of Fibrous Epithelioma at the Root of the Tongue." The diagnosis was extremely difficult. The form in which the disease presented itself was rare. When first examined, the tongue seemed normal, except for two prominences on each side at the base, which felt hard and firm. Grave doubts were entertained as to the exact nature for several months; finally, Dr. McBurney operated for carcinoma. An ulcer had formed, making the diagnosis more evident. The patient did well for a time, but finally died, without, however, a recurrence.

DR. BEVERLEY ROBINSON, of New York, read "A Report of Some Cases of Membranous Sore-throat." In the three cases reported there was great difficulty in diagnosticating between true diphtheria and membranous sore-throat of some other origin. The bacteriologic examination failed to disclose the presence of the Loeffler bacillus, while streptococci were present in abundance. Failure to find the Loeffler bacillus, however, does not necessarily disprove the existence of diphtheria. In case of doubt it is unwise to prematurely make a diagnosis of true diphtheria and cause the family alarm and trouble. At the same time certain precautions could be taken against unnecessary exposure of the well. Sulphur-fumigations are especially objectionable. The treatment might be that which would be adopted in a case of true diphtheria. Dr. Robinson spoke highly of the use of powdered cubebs, taken by the mouth in small pinches at frequent intervals. He condemned the custom of the health-officers in some sections of posting houses with diphtheria, as if persons passing such houses and not entering them were liable to take the disease.

Considerable discussion followed, and a resolution was adopted making as a subject for discussion at the next annual meeting, "The Best Means of Protecting the Public against the Spread of Diphtheria."

DR. MORRIS J. ASCH, of New York, presented a tampon, consisting of a hard-rubber tube, with perforations, for use after operations for deviation of the nasal septum. Dr. Asch also presented a set of Dr. Dessau's antiseptic electrodes, and Dr. Dessau's curette for adenoid growths.

DR. D. B. DELAVAN, of New York, proposed the administration of potassium iodide, in peptonized milk, in cases of tertiary syphilis of the throat, in which the ulceration had become so severe that the patient could not swallow with ease.

DR. J. WRIGHT, of Brooklyn, presented an improved forceps for the removal of adenoid growths in the post-nasal space.

DR. JOHN O. ROE, of Rochester, presented an improved Adams's forceps for straightening the nasal

septum, which possessed the advantage of enabling one to over-correct the deformity.

DR. C. H. KNIGHT, of New York, showed an improved snare for removal of the tonsils with a ring-safeguard.

DR. C. H. KNIGHT, of New York, read a paper entitled "Intubation for Chronic Stenosis in a Boy of Ten." According to the statement of his physicians, the boy had been ill for a week or more with dyspnea, aphonia, cough, and fever. There was a history of bad hygiene and poor diet. He could not whisper, and his breathing was quite noisy and labored. The dyspnea was decidedly more marked at night; it was relieved by inhalations of oxygen. The boy's condition grew worse. On examination a neoplasm was found beneath the vocal bands. The bands were red, and did not approximate on phonation. Beneath the cords, extending along their entire length and invading the anterior commissure, was a mass of tissue, paler in color than normal mucous membrane, having an uneven, and at certain points an almost papillary surface. No ulceration could be discovered. The air-passage was converted into an irregular, narrow slit. To relieve the dyspnea an O'Dwyer tube was introduced. This was worn intermittently for many weeks. It was impossible to get sufficient of the tissue to make a satisfactory microscopic examination. The process was at first thought to be tuberculous, but the absence of pulmonary signs and the marked change for the better after intubation pointed to simple subglottic papilloma. After about three months tracheotomy, thyrotomy, and radical extirpation of the neoplasm were proposed, but the case progressed rapidly to a fatal termination from general tuberculosis.

The points of interest were: 1. The simplicity of intubation as compared with tracheotomy, and the ease with which the tube was extracted, with the aid of cocaine and under the guidance of the mirror. 2. The slight amount of disturbance excited by the presence of the tube, and the absence of objection to its prolonged retention. Finally, the question suggested itself: Was it a case of primary laryngeal tuberculosis? The patient seemed much more comfortable than he could have been with the tracheal instead of the laryngeal tube.

DR. ALEXANDER A. MACCOY, of Philadelphia, read a paper entitled "Rare Forms of Laryngeal Growth," reporting a case of myxoma, and one of fibroma of the larynx. The first is quite rare; the second is not so infrequent. The myxoma seemed to have had its origin from the margin of the orifice of the ventricle. The patient's voice was completely restored after removal of the growth. In the other case most of the growth was removed by the cold snare, the remainder to be operated upon later. The tumor appeared to have sprung from the anterior and right surface of the arytenoid cartilage.

DR. H. L. SWAIN, of New Haven, reported "A Case of Tumor of the Larynx," relating the history of a case of fibro-myxoma of considerable size, attached by a pedicle to the anterior commissure of the vocal bands. The growth, the base of which was spread out over a greater surface than had been supposed, was removed with difficulty. Its removal had been followed by relief of the difficulty connected with phonation and respiration, and the patient had for two years remained free from recurrence.

DR. C. C. RICE stated that he has found it easier to apply the guillotine snare than the forceps in the removal of small laryngeal growths. Recently, in the case of a policeman, he had observed syncope follow the use of 4 per cent. solution of cocaine in the throat.

DR. LANGMAID stated that, on the recommendation of a European authority, he had used nicotine in an operation for the removal of a growth in the larynx in one case, and threatening poisonous symptoms developed.

DR. C. C. RICE, of New York, read a paper on "The Value of Sprays in the Treatment of Catarrhal Affections of the Upper Air-passages." He does not recommend the spray as a substitute for other methods of treatment. While some advantages attend the use of petroleum preparations, there is danger in their inconsiderate use, as a dry condition of the nasal passages may result. Such agents as iodoform and aristol lose much of their antiseptic property when used with oily agents, nor when thus used could their stimulating action be so well relied upon. In catarrhal affections of the upper air-passages nice judgment is required in selecting the drug, and particularly the strength of the solution to be used as a spray. The pressure should be regulated and the temperature should be adapted to the particular case. A weak solution of cocaine, say less than 1 per cent., is, perhaps, as good an astringent as any. A pressure of fifteen pounds to the square inch is sufficient for the anterior nares, while a pressure of from twenty-five to thirty pounds is necessary for a post-nasal spray.

DR. J. W. FARLOW presented a form of adenoid forceps which he had purchased in Paris, and had found an excellent instrument for the removal of adenoid growths in children and adults.

DR. JOHN O. ROE, of Rochester, read a paper on "The Correction of Deformity Resulting from Abscess of the Nasal Septum." In the case detailed there was, as is usual in these cases, marked thickening and widening of the dorsum of the nose proportionate to the amount of flattening. This thickened ridge of tissue was incised on both sides a short distance from the septum, at a point where it thinned into the alæ. The incision was made along the edge of the flattened tissue, through the cartilage of the alæ, to the under side of the skin, care being taken not to wound the latter. The skin was raised from the dorsum of the nose, and the flaps then turned upward and held in place by small ivory spring-plates on each side, having holes through which sutures were passed from one to the other, extending through the flaps. These threads were then tied so as to hold the flaps firmly in place, care being exercised not to strangulate the parts. The flattened condition of the nose was relieved, but not entirely. Owing to the entire absence of the triangular cartilage, there was not sufficient support to hold the nose upright. In order to increase the solidity of the septum, each side of the lower portion of the septum was first scarified, the front portion of the skin, however, being left intact. Wide, thick flaps were cut from the floor of the nostril opposite the portion of the septum which it was desired to render more rigid. These were turned upward and fastened together with clamps in the same way as the upper flaps.

The upper border of the flaps was also connected to the cut portion of the septum by means of fine sutures. The result was excellent. To maintain the nose in position until the parts healed, a small spiral spring was used.

DR. T. A. DEBLOIS, of Boston, read a paper on "The After-results of Nasal Cauterization." He related the histories of five or six cases in which he or others had cauterized the nose two or more years previously. In most of them the cauterization had been practised for an hypertrophied condition of the turbinated bone, and the immediate result, as far as relief of the symptoms was concerned, had been successful. Two years subsequently the patients had returned, again complaining of nasal obstruction. In some a rhinoscopic examination revealed, on either side of the original scar left by the cautery, the presence of swollen and projecting mucous membrane, which blocked up the nasal passages. In one case—a somewhat remarkable one—the mucous membrane, which was thrown in corrugated folds, had been cauterized frequently. Some of the cases showed, and doubtless many others would show, that the cautery may fail of the desired effects as a result of improper application, such as, on the one hand, making the scar-tissue too deep or, on the other, making it too shallow, and again of including in it too much tissue or not enough.

DR. J. H. BRYAN, of Washington, reported "A Case of Suppurating Ethmoiditis." The patient gave a history of having suffered from caries of an upper molar tooth. Her nose became closed; the secretions, at first watery, became thick and fetid. There was pain over the bridge of the nose, extending along the infra-orbital ridge to the temporal region. There were severe headache, pain on pressure of the eyeball, and a crepitating sensation below the orbit. On the left side of the nose were two mucous polypi attached to the anterior extremity of the middle turbinated bone. After snaring off the polypi, thick caseous secretion was observed to come from both the middle meatus and from above, between the middle turbinated body and the septum. Examination with the electric light showed the left antrum to be opaque, indicative of inflammation of the ethmoid cells. In spite of treatment, the conditions grew worse, until the abscess spontaneously discharged a large quantity of thick caseous secretion. After this the pain ceased and the general health improved.

The following are the officers for the ensuing year:

President.—Dr. Morris J. Asch, of New York.
First Vice-President.—Dr. S. Johnston, of Baltimore.
Second Vice-President.—Dr. J. C. Mulhall, of St. Louis.
Secretary-Treasurer.—Dr. C. H. Knight, of New York.
Libarian.—Dr. T. R. French, of Brooklyn.
Member of Council.—Dr. S. W. Langmaid, of Boston.

The next meeting will take place in New York in the last week of May, 1893.

CORRESPONDENCE.

THE LATE D. HAYES AGNEW.

To the Editor of THE MEDICAL NEWS,

SIR: At the request of Mrs. D. Hayes Agnew, I am preparing a biography of her late distinguished husband; in consequence, I am looking for data on this subject. Will you kindly announce that I am desirous of obtaining from all of Dr. Agnew's former friends, colleagues, associates, students, and acquaintances all authentic data in any way relative to his career or character? Dr. Agnew's acquaintance was so vast, and his life was so actively spent among his friends, while his own modesty was so marked, that undoubtedly a great many incidents, anecdotes, characteristic stories, etc., are unknown to his family. All material, however apparently insignificant or small, will be welcomed. Credit will be given to all data which is used. Yours faithfully,

J. HOWE ADAMS.

253 SOUTH SEVENTEENTH ST.

CHAIRMEN OF COMMITTEES OF ANATOMIC AND BIOLOGIC NOMENCLATURE: CORRECTION.

To the Editor of THE MEDICAL NEWS,

SIR: In a circular relating to "American Reports upon Anatomical Nomenclature," issued last winter by me as Secretary of the Committee of the Association of American Anatomists, in the third paragraph of the third page, the name of the Chairman of the Committee of the Anatomische Gesellschaft should have been Prof. A. von Kölliker, and that of the Chairman of the American division (appointed in 1891 by the American Association for the Advancement of Science) of the International Committee on Biologic Nomenclature should have been Prof. G. L. Goodale. I exceedingly regret the occurrence of the errors, due in the one case to my own misapprehension, and in the other to a clerical mistake.

BURT G. WILDER, M.D.

CORNELL UNIVERSITY, ITHACA, N. Y.

NEWS ITEMS.

"The Scalpel" is the name of a new monthly publication issued from the College of Physicians and Surgeons of Chicago, and under the editorial care of Dr. Louis J. Mitchell, assisted by two members of the class. Ventures of the kind of which this is an illustration are to be heartily encouraged as an indication of a progressive tendency, with which, however, the publication of an advertisement of a secret nostrum on the second page of the cover is entirely out of harmony.

The Lehigh Valley Medical Association will hold its twelfth annual meeting at Bethlehem, Pa., on Thursday, July 7, 1892. Dr. John B. Deaver, of Philadelphia, will deliver the annual address, the subject of which will be "Inflammation of the Right Iliac Fossa Associated with Lesions of the Cecum, the Vermiform Appendix and Adjacent Tissues."

Medico-Chirurgical College.—Dr. W. F. Haehnlen has been elected Professor of Obstetrics; Dr. W. E. Ashton, Professor of Gynecology, and Dr. C. M. Seltzer, Professor of Hygiene.

Dr. John Ridlon, formerly of New York, has been appointed lecturer on Orthopedic Surgery at the Chicago Medical College.